Maternal and Child Health Services Title V Block Grant

Federated States of Micronesia

FY 2022 Application/ FY 2020 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS
FSM National Government
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August 25, 2021

HRSA Grants Application Center
Attn: MCH Block Grant
Division of State and Community Health
5600 Fishers Lane, Room 18N33
Rockville, MD 20857

Dear Sir/Madam:

Transmitted herewith please find the MCH Continuing Grant Application from the Federated States of Micronesia seeking funding assistance for Maternal and Child Health Program Services for the Year 2022.

We hope that information contained herein meet your requirements. In the event that you require additional information please let us know.

Once again, thank you for this partnership.

Sincerely,

Mr. Moses Pretrick
Acting Secretary, FSM Department of Health and Social Affairs

Sent Electronically:

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

III.A.1. Program Overview

The goal of the Federated States of Micronesia (FSM) Maternal Child Health (MCH) Program is to provide comprehensive, coordinated and family-centered preventative services to pregnant women, post-partum women, infants and children, including children with special healthcare needs (CSHCN) from birth to 21 years.

There are two levels of government in the FSM, the National Government level and the State Government level. The National MCH Coordinator works in collaboration with other coordinators at the national level. The administration and management of the Title V Program is under the direct control of the National MCH Coordinator, who provides guidance and works closely with each of the four state MCH Coordinators for the planning, implementation and provision of direct services to the maternal, infant, child, and adolescent populations. Health services in the FSM are designed and delivered at the State level. The MCH Program provides primary care and preventive services to pregnant women; mothers and infants; preventive and primary care for children; and services for CSHCN.

To understand the challenges and context of the FSM, a brief review of the geographical location, political status, population, and the significant ethnic and linguistic diversity of the FSM is necessary. The FSM is an island nation with a total population of approximately **103,000** spread out over some 607 widely dispersed islands in the Western Pacific Ocean. The FSM is a constitutional federation incorporating four main states: Pohnpei, Chuuk, Yap and Kosrae. Kosrae State is the only FSM State composed of a single island. Surrounding each of the other three States are sparsely inhabited outer islands. Each of the FSM States are separated by hundreds of miles of Pacific Ocean accessible only by airplane or boat.

Politically, the FSM is freely associated nation with the United States under a Compact of Free Association entered into with the United States in 1986 with an amended compact entered into on June 30, 2004. Each of the four FSM States has its own constitution, elected legislature and governor. The governments of the FSM and the United States maintain deep ties and a cooperative relationship, with over 25 U.S. federal agencies that maintain programs in the FSM.

The people of the FSM are highly diverse with nine main and different ethnic groups speaking some thirteen (13) different languages. This highly diverse population with different languages or dialect use English to communicate across the four FSM states. English proficiency levels vary, with most of the older population being monolingual in their own native language or bilingual in another language, e.g. Japanese. Most of the younger population has basic English proficiency skills. In the FSM classrooms, children are taught in both their native language and English from first to third grade, after which English is used almost exclusively in middle-elementary to high school. What is truly unique about the linguistic context of the FSM is that each major language is not interrelated with the other language. Each has its own linguistic structure, pronunciation, vocabulary, sentence structures, and semantic, syntactic, and pragmatic rules. With the arrival of many Asian businesses to the FSM, other languages are being introduced, such as Filipino and Chinese. Health literacy across all inhabitants is low as higher education is not common in FSM. The MCH Program respects this cultural and linguistic diversity and seeks appropriately paired demographics within its staff, community leaders and families that participate in the program on each island state.

In 2020 the MCH Program conducted a community and stakeholder driven programmatic Needs Assessment of services provided to mothers and children in the FSM. FSM chose a conceptual framework for the needs assessment process that uses a primary prevention and early intervention –based approach with the goal of optimizing health and well-being among the MCH population across the life course, taking into account the many

factors that contribute to health outcomes. The needs assessment served as an essential tool to direct focus on system changes and examine the health status of FSM's families. Although there have been improvements in some areas, there continue to be disparities which still present challenges. The effects of the remote location preventing access to basic services as well as the population demographics affecting health literacy was seen in the identified priorities. Based on the assessment, FSM identified seven (7) MCH priorities that will provide guidance for MCH related activities and funding during 2020-2025.

In 2021 FSM MCH Program, acting on feedback provided in the 2020 MCH Block Grant Review Summary Statement, requested for Technical Assistance (TA) Training to address the recommendations made for the weakness cited in the 2021 Grant Application. Some of the weaknesses cited included the following; "many strategies and evidence-based or –informed measures (ESMs) are focused on health promotion, patient education, one-on-one health care provider and patient interactions, and provider training and education, which may not be effective strategies in showing improvements in data trends". "Denominator values vary across many National Performance Measures (NPMs), ESMs, and State Performance Measures (SPMs), and limited information is included in the field notes to explain the drastic changes in denominators from year to year. Therefore, data trends are difficult to evaluate, which makes it difficult to measure program success", etc. A Technical Assistance (TA) Training was authorized for FSM and Dr. Haley Cash conducted a Virtual TA Training on May 18, 20, 25 and 26, 2021. The TA Sessions are two hours long, each, and attended by the National and State MCH Program Coordinators and key staff.

As an outcome of the TA Training some strategies and Evidenced-Based Informed Strategic Measures and Strategies were either changed or modified and some NPM were replaced with SPM in order for us to properly tract program success based on the Priorities selected by the MCH Program in the Federated States of Micronesia (FSM).

Priorities and National Performance Measures

Priority	Performance Measure
Women/Maternal	
Access to health services- Improve women's health through cervical cancer and anemia screening	SPM #1 Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening SPM #2. Percent of women (15-44 years old) screened for anemia in the past year
Perinatal/Infant	
Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	SPM #3 Percent of pregnant women who are screened for gestational diabetes by 24-28 weeks.
Child	
Improve child health through healthy weight through physical activity and nutrition promotion	NPM #8 Physical activity: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Adolescent	
Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior and poor outcomes	SPM #4 - Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools
CSHCN	
Provide care coordination training for parents/caregivers of CSHCN	NPM #11 Medical home: Percent of CSHCN, ages 0 through 17, who have a medical home
Cross-Cutting	
Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits	
Systems Building	
Improve health promotion communication	SPM #5 – Percent of FSM Nationally-led MCH health message campaigns created through policies and uniform messages.

Women/Maternal Health

The FSM maternal health clinics serve as many women's first entry into medical care or their medical home. MCH recommends and provides preventive health services in accordance with recognized standards of care. The program aims to improve clients' access to preventive health services through cervical cancer (Pap & VIA) and anemia screening. Because the preventive health clinics of the FSM all exist within the public health facilities, clients can avail themselves of multiple public health screening and preventive services in one visit. In this way, The MCH Program serves as the gateway to care through partnerships with other public health programs and other health and social programs. Once again, clients need not make multiple appointments or visit multiple clinics to participate in these program services, thereby allowing for comprehensive and cohesive preventive health care.

Perinatal/Infant Health

The perinatal mortality rate in the FSM is at least three times that of the national average. An assessment of prenatal care in the FSM showed that only about 31% of women come in for care during the first trimester. In addition, some FSM states report up to 10% of deliveries received no prenatal care at all. MCH Program continues to strive to improve prenatal care adequacy. The process of prenatal care at the clinic may be a deterrent to some women. Streamlining the process may increase prenatal care attendance. Even amongst those seeking prenatal care, that care is not always adequate. There is limited pregnancy expectation education so the community is unaware of what to anticipate during pregnancy and prenatal care. Unplanned pregnancy, late access and inadequate prenatal care, limited preventive health screening services, and poverty play a significant role in poor birth outcomes, causing additional stressors on the family, community, the health care system and the government. The MCH Program is committed to improving prenatal care access and adequacy through the MCH clinics and dispensaries in remote villages.

Child Health

Physical activity is not tracked well in the FSM. In addition, it is uncertain if all children's health care providers are aware of the recommendations for physical activity for children and if this is promoted during well children visits. FSM children experience a higher rate of being overweight as compared to the US. Unfortunately, post WWII with the introduction of western culture, locals began eating processed foods such as canned meats and rice. This diet has been integrated into the culture of the locals and is considered "traditional food". Processed foods are affordable and plentiful in this remote area where fresh ingredients are often hard to come by, perishable, and expensive for the average FSM resident. This highly processed diet in a population with a strong genetic propensity to diabetes and hypertension leads to devastating rates of diabetes, heart disease, stroke, renal failure and dialysis in patients much younger than the average age in the US mainland. FSM MCH Program intends to start young to combat obesity and nutrition to prevent non-communicable diseases.

Adolescent Health

FSM teens have a high rate of pregnancy, sexually transmitted diseases, alcohol use, non-fatal motor vehicle crashes and suicide. The MCH goal is to encourage positive health behavior activity in adolescents, through comprehensive interventions at age-appropriate levels in a culturally-sensitive manner that will impact the frightening possibilities of adolescent risk behavior activity. Currently the FSM MCH program provides school physicals until age 12 but not again unless required for college entry. As such, well adolescent visits do not occur with regularity. The Program plans to expand these school physicals into the high school grades. During these well adolescent visits, youth will receive assessment on violence and safety and information and education on risky behavior and its possible negative outcomes.

Children with Special Health Care Needs

Most children in the program are identified through Child Find a program of Special Education, when diagnosed as deaf or hard of hearing, or seen and referred by Shriners during Shriners annual visit. Diagnosis often depends on specialist visits from off island so MCH provides gap care until the next specialist is on island. Interventions for those with delays do not begin until age 3 with Special Education, therefore the MCH program provides gap care for these children as well. The CSHCN Program in FSM relies heavily upon its partnership with the Special Education. Although the strong relationship is an asset, the CSHCN Program needs to do more distinct work with their population, including providing care coordination services.

Cross Cutting

Although FSM MCH sees behavioral/mental health as a need across populations. However, given the reality of the situation in the FSM (limited infrastructure and resources to do screening) FSM MCH will continue to track behavioral health screening of our mothers for our policy and decision-making use BUT this will not be a reportable indicator to MCHB per this application.

Systems Building

Impeding priorities in families' life creates challenges and barriers in seeking preventative health screenings. Poor health literacy contributes to not seeking preventive health services as individuals may not understand the connection of prevention in relation to their general health. The MCH Program has to be in the forefront of providing guidance to communicate the importance and availability of health services throughout the lifespan including healthy behaviors and resources. The MCH Program is committed to developing guidance through policies and procedures for basic MCH initiatives. In addition, MCH National will develop common educational messages for their communities to be shared by the State Programs to provide unity, organization and consistency while still allowing for some State individualization on certain provisions of the program.

FSM's MCH Program historically has a solid working collaboration with the public and private sectors as well as governmental and non-governmental organizations. The MCH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. Much of the work accomplished by MCH staff is done in collaboration with other state agency staff, particularly Public Health and Education. MCH personnel work with other state agency staff on a nearly daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements. The FSM MCH Program is well-integrated with Family Planning Program, Immunization Program, Substance Abuse and Mental Health Program, HIV/STD Prevention Program, Non-Communicable Disease Unit including Diabetes, Cancer, Tobacco Control, and the FSM Department of Education, in particular the Early Intervention Service. The MCH Program works with each FSM State's Community Health Centers to improve accessibility and expand primary care services for low-income and vulnerable populations. The MCH Program has an established working partnership with the College of Micronesia for training needs of both clinical and programmatic staff, conducting awareness activities in nutrition and physical activity, and to prevent and control non-communicable disease. The MCH Program staff at the state level work closely with parents' support groups, church leaders, women's groups, and community and traditional leaders.

The FSM does not have the following programs or services: Title V- H.O.M.E. Visiting, Title XIX - Medicaid, Title XXI - Child Health Insurance Program, Social Services, Child Welfare Programs, Social Security Administration, WIC Program, or Rehabilitation Services.

The MCH Program leverages funds and resources from and works with international agencies such as Red Cross, World Health Organization and United Nations Children's Fund and Population Fund.

III.A.2. How Federal Title V Funds Support State MCH Efforts

MCH Block Grant Funds are used to support the overall MCH efforts in the Federated States of Micronesia (FSM). Primarily, Block Grant funds support Enabling Services to improve and increase access to health care and improve health outcomes of the FSM MCH population. The types of enabling services supported include: Care/Service Coordination for Children of Special Healthcare Needs, Laboratory Supplies for Newborn Screening, Health Education and Counseling for Individuals, Children, and Families, Outreach, and Referrals. Public Health Services and Systems are also supported through MCH Block Grant dollars. Supporting activities and infrastructure to carry out core public health functions in the FSM is critical for the efforts being made towards improving population health. Specifically, MCH Block Grant funds are used to support policy and system development, annual and five-year needs assessment activities, education and awareness campaigns, program development, implementation, monitoring and evaluation. Additionally, funds are used to support workforce development towards building capacity among MCHB staff, nurses, and partners who impact FSM's Title V Priorities.

III.A.3. MCH Success Story

Since March 2020, FSM has restricted their borders to incoming passengers from airlines and vessels because of COVID-19. This extreme measure is needed because FSM does not have the resources, such as medical personnel and equipment, to cope with a COVID-19 outbreak. The professionals who typically travel to the islands cannot provide resources and services. To help mitigate this challenge, the Federated States of Micronesia Maternal Child Health program applied and was awarded $100,000 from the Association of Maternal and Child Health Programs and $10,000 from Early Hearing Detection and Intervention (EHDI) Program supplemental funding. Both programs allowed the FSM MCH program to provide tele-health services. Telehealth support is needed so that children can receive diagnostic audiological evaluations and other needed services and resources, such as early intervention, aural habilitation, and speech and language therapy services. Funding supported the installation of a dedicated internet line for Yap State Public Health with laptop, speakers, and headphones, the procurement of Awake ABRs and other audiological equipment, and procurement of tablets for parents and families of children with special health care needs to access information and activities related to development and intervention. Training was also provided to MCH staff and families as part of this funding on the use of equipment, and flyers on speech and language development were developed for island states in their respective languages. Since FSM got the machines and conducted training in April 2021, we have tested about a dozen children via tele audiometry, including a 2-month-old, who was FSM's first 1-3-6, got tested and received services from our contracted Speech Pathologist….so that's a success there. If we didn't have this, no way to identify and no way to provide services.

III.B. Overview of the State

II.A. OVERVIEW OF THE STATE

The Federated States of Micronesia (FSM) is made of four group of island states: Pohnpei (the Capital state), Chuuk (the largest in population), Yap, and Kosrae (the smallest, one-island state). Altogether, the FSM has 607 small islands located in the Western Pacific, about 2,500 miles southwest of Hawaii. Some of the islands are volcanic and others are small atolls. Except the state of Kosrae doesn't have any other smaller atolls. The four FSM states are widely spread apart by the ocean, hundreds of miles from east to west. From farthest east is the state of Kosrae, which is more closer to the islands of the Republic of the Marshalls than to the islands of Yap, then going Westward to the states of Pohnpei, Chuuk, and farthest west is the state of Yap, which is more closer to the islands of the Republic of Palau than the rest of the FSM. The four states are united and regulated under the FSM National Constitution.

https://fsmcfatf.com/contact-us/

States Geography & Demography

Chuuk State

Formerly known as Truk District, was one of the six districts of the former Trust Territory of the Pacific Islands (TTPI), which were administered by the United States of America under the Trusteeship of the United Nations after World War II. In 1979, four of the six former districts chose to end the trusteeship and form a new government, which is now called the Federated States of Micronesia. Chuuk is one of the four states of the Federated States of Micronesia (FSM). It is the most populated State among the four states with an approximate population of 48,000 during the 2010 FSM Census. It has two major volcanically formed island groups, located in the lagoon with mountain peaks, and they are divided into two regions--the Namoneas region and the Faichuk region. The Namoneas region is divided into the Northern (Weno, Piis-Panew, and Fonoton Islands) and Southern (Fefen, Uman, Tonoas, Etten, Siis, and Parem Islands). There are also the "outer island" groups: the Mortlock Islands to the southeast, the Hall Islands (Pafeng) to the north, Namonuito Atoll to the northwest, and the Pattiw region to the west. These islands are coral formations and are situated outside the lagoon.

The State of Chuuk consists of 15 high volcanic islands in the Chuuk Lagoon and a series of 14 outlying atolls and low islands. There are three geographic aspects to Chuuk, the administrative center of the state on the island of Weno (formerly Moen), the islands of the Chuuk Lagoon, and the islands of the outlying atolls - a total of approximately 290 islands. The 15 islands of the Chuuk Lagoon have a total land area of 39 square miles; and the lagoon itself has a total surface area of 822 square miles surrounded by 140 miles of coral reef. Because of the vast expanse of water between islands, travel within the state is difficult. Within the lagoon, travel by boat from Weno to any of the other islands will take from 1.5 hours to 2 hours. Access to the outer islands is even more difficult with travel times on a cargo ship taking from four hours up to two days. The provision of health care, including MCH services, to the population is made difficult by the lack of transportation and communication between widely dispersed, small clusters of the populations on outer and lagoon islands. Of the total population of Chuuk of 48,651 residents, 32,738 (67% of total state including Weno) live on the islands in the Chuuk Lagoon. The administrative center, Weno Island claims 14,113 residents (29% of total state), followed by Tol (4,579), Tonoas (3,517), Fefan (3,471), Uman (2,554), Udot (1,680), Polle (1,498), Patta (1,107), Romanum (865), and Fanapanges (672). The remaining islands have less than 650 residents each. Approximately 48.7% (23,697 persons) of the total Chuuk population are under 20 years of age. Of this group, 5,987 are children under 5 years of age. The median age is 20.7 years, which makes it the youngest population in the FSM. There are 10,806, (22% of the female population) women of child-bearing ages between15-44 years that live in the state.

Kosrae State

Kosrae, formerly known as Kusaie, is the easternmost State of the Federation with 42 square miles of land and no lagoons. It is located approximately 370 miles north of the equator, between Guam and the Hawaii Islands. Kosrae is an Island State, and it is subdivided into four major municipalities: Tafunsak, Lelu, Malem, and Utwe. The 2010 FSM Census also indicates that the 6,616 persons lived in 1,143 households with an average household size of 5.7. Kosrae's population of 6,616 (2010 FSM Census) made up 6% of the total FSM population. In comparison with the other three FSM States, Kosrae is the least populated, the only single-island state, is the furthest southeastern point of the four states. Kosrae is the second largest inhabited island in the FSM with a land area of approximately 42.3 square miles. Because of the steep rugged mountain peaks, all of the local villages and communities are coastal communities connected by paved roads. Travel around Kosrae island is not difficult and it is possible to drive from one end of the island to the other end in approximately two hours. The community of Walung (approximate population of 200) is part of Tafunsak municipality, is isolated and only accessible by a ½ hour boat ride at high tide. Of the total Kosrae population of 6,616 residents, 2,173 people reside in Tafunsak, 2,160 persons in Lelu, 1,300 in Malem, and 983 residents on Utwe. Approximately 47% (3,135 persons) is less than 20 years of age and of that group 798 (12%) are less than 5 years of age. The population of women 15-44 years number 1,369 and comprise 20.6% of the total female population.

Pohnpei State

Pohnpei State, formerly called Ponape, is the Capital of the Federated States of Micronesia (FSM) and the largest Island in the four FSM States. It is also the second largest populated State in the FSM. Pohnpei Island is encircled by a series of inner-fringing reefs, deep lagoon waters and an outer reef. Pohnpei has two groups of outlying atolls which are made of corals. The eastern atolls consist of Pingelap and Mokiloa, and the southern atolls consist of Sapuwafik, Nukuoro, and Kapingamarangi . The Nukuoro and Kapingamarangi people are of Polynesian origins.

The main Island of Pohnpei is located at approximately 6 degrees 45 minutes north latitude and 158 degrees 15 minutes east longitude which is about 2,600 miles southwest of Japan, 2,200 lies east of the Philippines, 3,100 miles east of Hawaii, and 500 miles north of the equator. The island of Pohnpei, the largest island in the FSM, is approximately 13 miles long with a land mass of 129 square miles. There are five municipalities of Pohnpei Island, plus the Kolonia Town, which is the Capitol City of Pohnpei State. They are: Madolenihmw, Kitti, U, Nett, and Sokehs.

Majority of Kolonia Town residents are from the outer islands and from outside of Pohnpei State. The total population of Pohnpei State is 35,981 (per Census in 2010), 39% on the outer islands while the rest is distributed throughout the five (5) municipalities and the Kolonia Town. Of the outer islands of Pohnpei, to the south lies Kapingamarangi (410 miles from Pohnpei proper), Nukuoro (308 miles), Sapwuahfik (100 miles), Oroluk (190 miles), Pakin (28 miles), and Ant (21 miles). To the east lie the islands of Mwoakilloa (95 miles) and Pingelap (155 miles). These outer islands together comprise a land mass of approximately 133 square miles and 331 square miles of lagoons. Travel on the island of Pohnpei proper is increasingly easier to outlying communities with the completion of pavement of the road around the island. However, because of scattered housing along feeder unpaved dirt roads, there are still many residents who have difficulties in accessing health care, including MCH. The outer islands are the most difficult to reach because of the infrequent and undependable cargo ships. The regular field trip on the ship takes place once a month to each of the outer islands. The population of Pohnpei is 35,981 residents. Based on the annual population growth rate, the population is projected to reach 41,033 by the year 2025. About half (46.7%) of the population (16,832 persons) are less than 20 years of age with the median age of 21.8 years. There are 8,250 women of child-bearing age between 15-44 years comprising 46.4% of the female population.

Yap State

From farther east to west, the FSM states are Kosrae, Pohnpei, Chuuk, and Yap State. Yap State or Wa'ab, formerly known as Yap District, was one of the six former districts of the former Trust Territory of the Pacific Islands (TTPI), which was administered by the United States of America under the trusteeship of the United Nations after World War II. It is located midway between Guam and Palau. Yap Proper is comprised of four high, volcanic islands--Yap, Gagil, Tomil, and Rumung. Among these islands, there are 22 inhabited ones, including Ulithi, Woleai and Satawal, whose population speaks three different languages, other than the Yap proper main language. Two-thirds of its estimated population of 11,377 residents (2010 Census population) lives on Yap Island. The rest are scattered throughout the Outer islands.

The town of Colonia on Yap proper is the capital. Yap has a total of 78 outer islands stretching nearly 600 miles east of Yap Proper Island of which 22 islands are inhabited. Although these islands encompass approximately 500,000 square miles of area in the Western Caroline Island chain, Yap state consists of only 45.8 square miles of land area. Most of the outer islands are coral atolls and are sparsely populated. Transportation on Yap Proper is easier because of the development of paved roads; however, there are clusters of villages that are still inaccessible to health and MCH services because of unpaved dirt roads. The outer islands are also difficult to reach because of infrequent cargo ships. The regular ship field trip is once a month to each of the outer islands bringing supplies and health personnel to deliver goods and services. The population distribution are: *Yap Proper* with 64.7% (7,371 persons); *Ulithi Lagoon* has four inhabited islands (Asor, Falealop, Fatharai, Mogmog) with a population of 847 residents (7%); *Wolaei* is comprised of two lagoons (the West Lagoon and the East Lagoon) with five of the 22 islands inhabited with a population of 1,039 persons (9%); *Fais*, population 294; *Eauripik*, population 114; *Satawal*, population 501; *Faraulep*, population 193; *Ifalik,* population 578; *Elato*, population 105; *Ngulu*, population 6; and *Lamotrek*, population 329. The median age for Yap is 25.1 years; the highest median age among the four states. Approximately 42.7% are under 20 years of age (4,864 persons). There are 2,545 women between 15-44 years, which is 44% of the total female population.

National Demographics

Although the FSM population size in 2010 census was estimated at 102,843 persons residing in 16,767 households, the current FSM population size depicted in the FSM 2013-2014 HIES was estimated at 103,382 compared to 102,843 in 2010, indicating a population increase of 0.5% representing about 539 more people. The average household size remains about the same with 6.1 persons per household in 2010 and 6.2 in 2013.

According to the FSM Statistics 2010 Housing Characteristics Report, it was stated that similar to the population statistics, the housing and household information is derived from the regularly conducted Population and Housing Census in the country and its states.

The projected census data from 2016 to 2020 was shown below in Table 2.

Projected Population by State (2016-2020)					
State	2016 *Total*	2017 *Total*	2018 *Total*	2019 *Total*	2020 *Total*
FSM	102,453	102,622	102,797	102,980	103,169
Chuuk	46,688	46,503	46,322	46,145	45,973
Kosrae	6,227	6,181	6,135	6,090	6,047
Pohnpei	37,893	38,236	38,583	38,932	39,282
Yap	11,645	11,701	11,758	11,813	11,867

Source: FSM Statistics Office

According to World Bank, the FSM's latest demographic in 2018 is depicted below:

Life expectancy: 67.8 years (2018) World Bank
Fertility rate: 3.05 births per woman (2018) World Bank
GNI per capita: 3,400 PPP dollars (2018) World Bank
Population growth rate: 1.1% annual change (2018) World Bank

System of Care Population Served

The 2019 FSM population projection estimates showed that there were 22,642 women of reproductive age (defined as women 15-44 years old). It was reported that about 21% of the women of reproductive age had received direct services from the MCH programs in 2019.

2019 FSM Census POPULATION ESTIMATES			
Sex/Age	**Total**	**Male**	**Female**
Total	**102,980**	**52,243**	**50,737**
0 to 4	10,734	5,557	5,178
5 to 9	11,308	5,822	5,486
10 to 14	11,324	5,767	5,557
15 to 19	11,326	5,828	5,498
20 to 24	10,840	5,596	5,244
25 to 29	8,658	4,556	4,102
30 to 34	6,012	3,156	2,856
35 to 39	5,110	2,530	2,580
40 to 44	4,804	2,442	2,362
45 to 49	4,704	2,242	2,462
50 to 54	4,644	2,227	2,417
55 to 59	4,366	2,179	2,187
60 to 64	3,760	1,828	1,932
65+	5,391	2,514	2,877

Sources: FSM Census Population Projection

The number of infants (less than one year old) in the 2019 FSM population projection was 2,156. The 2019 population estimates show that there were 19,886 children 1- 9 years of age. There were 22,650 children 10-19 years of age in the FSM. The MCH programs served 46,502 of these groups (0-19 years old) including the CSHCN population.

Government

One of the strengths that impact the health status of the FSM MCH population is the existing governmental structure. Although the FSM National Constitution holds the four FSM states together, each of the four states has its own state Constitution. Each of them replicates that of the national government with three branches of separate powers. Each of the FSM states has considerable autonomy and each one of them is equally unique in its own geography, ecology, language and cultures. Each state has unique cultural characteristics which are as important as the others. One of the known challenges that the four MCH programs encountered is the cultural diversity which in itself is challenging and typified by the existence of eight major indigenous languages (Chuukese, Kosraen, Pohnpeian, Yapese, Ulithian, Woleaian, Kapingamarangi and Nukuoro). However, with the existence of English language as the official language throughout the islands in the governments, schools, and commercial businesses, it lessens the burden of not understanding one another when languages become the barrier.

The President and the Vice President of the Federated States of Micronesia are the highest Chief Executives of the FSM. They are elected from among fourteen members of the National Legislative branch, which is the national Congress. Four of them represent each of the four states for four-year terms, and the other ten members apportioned based on the population. They only serve their terms for two years. Currently, Chuuk has six seats in the Congress, Pohnpei has four, and the remaining four are two seats for Yap and two seats for Kosrae. All members of the Congress get elected by their respective state eligible, registered voters.

The four states are united and regulated under the FSM National Constitution. The Constitution provides separation of power of the three branches of government, the Executive, Legislative and Judiciary. Unlike the USA, most of the

government functions are carried out at the state levels, except foreign policy and national defense are carried out at the national level.

Each state governments under their constitutions are structurally similar mimicking the national government, all utilizing three co-equal branches of government, the executive, legislative and judicial. Each of the state constitutions contain provisions recognizing and preserving local custom and tradition.

People, Cultures, and Religion

People from the FSM are classified as people from Micronesia (The Micronesia region encompasses five sovereign, independent nations—the Federated States of Micronesia, Palau, Kiribati, the Marshall Islands and Nauru—as well as three U.S. territories in the northern part: Northern Mariana Islands, Guam and Wake Island) according to Wikepedia.org. Traditionally, like the rest of the Micronesians the FSM people rely on fishing and farming for subsistence. Skills such as woodcarving, traditional canoe and cottage constructions, fine weaving from hibiscus and coconut palms are regularly practiced and carried on as part of their traditional culture. The older people teach and pass them down to the younger generation.

Christianity is the predominant religion in the FSM, divided between Roman Catholic (50%) and Protestant (47%). Churches of many denominations can be found throughout the islands. Other churches (3%) include Latter-Day Saints, Seventh-Day Adventist, Assembly of God, Jehovah's Witnesses, and the Baha'i Faith. In 2015, a Muslim society, the Ahmadiyya Muslims was registered in the country (Kosrae State) despite stiff opposition from the locals.

The people of the FSM are generally known as friendly people. They have a relaxed island lifestyle which very common among the island people. They have their own culture for particular ethnic group, and religion plays a major role in the culture. For example, Sundays in Kosrae, is a
day of worship and for rest. Almost all stores and shops are closed on Sundays. Drinking alcohol on a Sunday is prohibited.

Culturally, there are important aspects to FSM culture that give context to the development of an effective FSM prevention infrastructure. Islanders have not completely understood the concept of medical confidentiality and many people are reluctant to be seen and examined by the physician, nurse or health aide. Because of this reluctance and lack of understanding of preventive measures, people seek medical care only when conditions are too serious to be ignored any longer, and sometimes that is too late. Micronesians often believe that illnesses and other diseases are brought upon a person by gods and/or ancestors for various reasons (such as punishment for certain members of the family or clan who have offended the gods or ancestors), and illnesses are thought to be remedied only by reconciliation of the gods, families or individuals.

Language

The cultural diversity is challenging and typified by the existence of eight major indigenous (Chuukese, Kosraen, Pohnpeian, Yapese, Ulithian, Woleaian, Kapingamarangi and Nukuoro) languages in the FSM. However, with the existence of English language as the official language throughout the islands, in the governments, schools, and commercial businesses, it lessens the burden of not understanding one another when languages become the barrier. English is taught in the schools throughout the Islands in the FSM. Several older people speak Japanese, the language they learned during the Japanese Administration before the World War II. English is the official and common language. Beside it the following Austronesian languages are being spoken in the FSM: Chuukese, Pohnpeian, Kosraen, Yapese, Mortlockese, Ulithian, Satawalese, Kapingamarangi, Nukouro, Woleain, Pwuluat, Ngatikese, Mwoakilese and Pingilapese.

Economy

Since the inception of the FSM independent government, the government has become the main employer of the Island. Like today, the public sector continues to depend greatly upon the assistance provided to FSM under the Compact of Free Association Agreement, other federal grants and foreign grants. Majority of the people in the FSM earning an income are employed by either the State government or the FSM National government. The private sector relies on the moms and pops retail stores, restaurants, and hotels, and farming and fishing.

In the recent FSM 2013-2014 Household Income and Expenditure Survey (HIES) report, it stated that in all four FSM states, wage and salary income make the most significant contribution to total HH income. There is a large degree of difference in household (HH) income in Chuuk when compared with the three other states of the Federated States of Micronesia (FSM). Average annual HH income in Chuuk is US$8,415 while it is around US$15,500 in other states. Kosrae has a high proportion of income in the form of cash (94%), while in all other states, cash makes up around 80% of total HH income. The large majority of the remaining income is subsistence – the value of items that are home-produced and consumed by the HH. The distribution of income for all states diverts significantly from equality, showing that there is a significant degree of income inequality in FSM.

https://fsm-

	Yap	Chuuk	Pohnpei	Kosrae	National
Average annual HH income	$15,843	$8,415	$16,708	$15,141	$13,093
Median annual HH income	$10,660	$4,373	$10,266	$8,330	$7,336
Proportion of HH income that is cash	77%	81%	86%	94%	84%
Proportion of HHs generating subsistence income	96%	84%	69%	75%	79%
Proportion of HHs in national income Q1 and Q2	35%	63%	24%	30%	40%

data.sprep.org/dataset/federated-states-micronesia-2013-14-hies-states_income/resource/

According to the Poverty Profile of FSM, 2013, about 10% of the people in FSM spend below what is needed to secure a minimal health diet. When both food and nonfoods are considered, 41.2% of the population live below the total poverty line. The poverty gap index, which indicates the extent to which average adult equivalent expenditures fall short of the poverty lines, is estimated at 3.6% at the food poverty line and 15.1% at the total poverty line. Generally, poverty is most severe in Chuuk: With more than 16% living below the food poverty line, Chuuk primarily drives FSM's overall food poverty rate. No Kosrae household lives below the food poverty line, and food poverty in Yap and Pohnpei are 10% and 2.6% respectively. The fact that poverty is relatively higher in Chuuk even when the poverty line is the lowest there implies that incomes are lower in Chuuk than elsewhere.

FSM is not eligible for US Medicare and Medicaid Programs. It is also significant that in the FSM, there are no cash-supplemented welfare programs except the FSM Social Security Benefit program. Therefore, services provided by the MCH programs are free to the public.

Transportation

Nowadays people on the islands rely on vehicle transportation to go from one village to another and the only 2 national ships that provide services among the main islands and the outer islands. Shipping services to and from the four FSM States are provided by outside shipping companies like Kyowa Line from Japan, Mariana Express Lines Pte. Ltd. from Singapore and etc. Currently, the United Airline is the only commercial airline that provides flight services to and from United States of America to the four islands States via island hopper en-route Guam once a week. Transportation within and between states significantly impacts the quality and coordination of health care, including MCH program services. Yap is additionally serviced by Pacific Missionary Aviation (PMA), which makes

regularly scheduled trips from Yap to Ulithi and Woleai atolls. With the exception of Ulithi and Woleai Atolls, no other outer islands in Yap receive air transportation. Caroline Islands Air (CIA) services Pingelap, Mokil and Sapwuafik, three of the outer islands of Pohnpei, twice a week and to Ta Atoll, in the Mortlocks Chuuk, once in two weeks, is currently immobilized due to the Covid-19 Pandemic. Major field trip ships to the outer islands are operated by the National Transportation Department and field trip schedules are shared with the States government., Smaller inter-island ships on which health service field teams make intermittent trips are operated by local state government or private companies. In cases of medical emergencies, these ships and/or the PMA and CPA airlines evacuate patients. Transportation provided by airplane, small private motor boats or canoes, is very expensive domestically within the FSM four States or within individual lagoons.

Healthcare System

The FSM National Government Department of Health and Social Affairs provides advice and support to the FSM states. Each state has its own health services department. There is only one hospital in each State and several private clinics in two States. They also have a few community health centers that are serving the community people in the villages. The health centers are more accessible to the community people than the hospital. The hospital in each state serves more as a last resort for the sick people to seek for health care if the community centers do not have what they need. Very few doctors are available at the community clinics to assist the regular or daily health assistant. Not all the centers have adequate medical supplies and equipment. However, most people on the islands prefer to visit the health centers because they are closer to their homes, and they have affordable medicines.

Title V programs are a key entry point into the health care system. For young and low-income women who are more likely to utilize Title V/MCH program clinics as their main source of medical care. The Title V services provided through the FSM MCH program clinics are a vital source of care for the many uninsured individuals in the four FSM States. Nationally, more women who utilize MCH program services consider it their usual source of care, a number that is even higher for women in poverty, with no public insurance or no insurance at all. The importance of Title V clinics' roles in helping manage women's health care needs above and beyond reproductive health, and as an entry point into the health care system cannot be overstated, especially given the shortage of primary care providers throughout FSM. The Public Health and MCH program clinics serve as FSM's main provider of primary care for low-income women, children and families providing preventive medical visits, prenatal care, well-baby and well-child care, routine immunizations, and developmental screening at no cost, across generations for most families.

There are five (5) Department of Health Services in the FSM; one at the national level and four at the State levels. All of the departments of Health services in the four States do serve the population domains under the MCH program. Mostly, the Public Health is in charge of the primary care programs to such population domains. The Health services are provided by the State Department of Health Services and other health programs; both primary and secondary health system of cares are made available through the State hospital only. Patients with complications or those requiring tertiary cares are referred off-island to Guam, Philippines or Honolulu, depending on availability of funds provided by either the State governments or Micare Health Insurance.

General Health

The highlights of the 2018 FSM BRFSS Comprehensive Report include the general overview of the general health and health-care accessibility among the adult respondents, prevalence of chronic diseases, and their health-risk behaviors. Among the 2,712 survey respondents, 71.3% of respondents said they did not have health-care coverage. Of the total, 70.3 % of the males did not have health-care coverage and 72.3% females lacked health-care coverage. In total, 5.3% of FSM respondents rated themselves to be in poor health. The data showed that female respondents are more likely to have poor health than male respondents. High ratings for one's poor health were most common among individuals in the oldest age groups. More than 90% of the survey population reported that they have fair to excellent health. One out of ten individual respondents mentioned that they had 14 or more mentally unhealthy

days during the previous 30 days.

The most-common chronic disease in the FSM was high cholesterol, hypertension, arthritis, asthma and diabetes. Those who reported ever having high cholesterol was among female
respondents (45.7%); males reported ever had high cholesterol (37.1%). The highest prevalence of high cholesterol was shown among FSM respondents aged 55 to-64 years old (61.2%). Overall, (37.8%) in the survey population are obese. There was a significant gender difference in obesity. A higher percentage of females (44.5%) reported being obese than males (32.9%). About one-third of the study population (32.2%) was overweight. The percentage of overweight in males (33%) is slightly higher than overweight in females (31.1%).

The prevalence of current daily tobacco smokers was 13.3 % and less than daily tobacco smokers was 8.6%, significantly higher in the male survey population. The highest percentage of current daily smokers was in the age groups 45-54 years old, while current less than daily smokers was in the earliest age groups 18-24 years old.

Integration and Financing of Services

Youth Suicide and Youth Mental Health in the FSM

There have been some assumptions that culture may contribute to suicidal behaviors but there is a lack of research in terms of suicide across the different cultures. The development of necessary evidence-based interventions for the prevention of suicide has been affected due to this lack of research.

According to current FSM Behavioral Health & Wellness program Psychiatrist, Dr. Victor Wasson, he said "I feel that more of this much needed research is to be done in order to ensure that we establish prevention/intervention strategies that are culturally orientated/sensitive". He has stated that mental illness may have not been an important factor in Micronesian suicides but this can be debated (due to the lack of expertise for identification/diagnosis during that time, lack of awareness/under-reporting along with the stigma that accompanies them and the cultural explanations of certain symptomatology with traditional management if any). Among the victims who were actually diagnosed with a mental illness (10%), the common illness was schizophrenia. Alcohol was blamed as a contributing factor towards suicide method motivation or method. It was stated that 41%- 68% were intoxicated/drinking at the time of completed or attempted suicide.

The most common methods used in Micronesia among men (86%) and women (69%) is by self-strangulation/asphyxiation or in other words hanging. There may have been a cultural patterning of this particular method having not been influenced by models of a foreign kind.

Following were major reasons for committing suicide in the FSM:

1. Alterations in the family relationships and structures following the colonization periods and moving on into a new era where change is inevitable.
2. A reduction in dependence on subsistence production and more reliance on cash economy may have affected the importance of clan activities and lineage.
3. Undermining of the social supports structures for adolescents caused by unaccustomed reliance on the nuclear family leading to a rise in parent-adolescent conflicts
4. Suicide has somewhat been accepted/expected (to some extent) and become more familiar among youths in the resolution of conflicts/social problems faced in society.
5. The Micronesian belief system that pertains to communication in spirit may also be another factor for influence from one suicide to another.
6. Despite the findings that suicides were a result of impulsive behavior, there is a trend involving long term

intolerable situations and the preference to withdraw and handle matters indirectly rather than confrontation.

According to the 2018 FSM BRFSS National Report, more than 10% individuals reported that they had more than 14 mentally unhealthy days. There was gender similarity when reported ever had more than 14 mentally unhealthy days each month.

Financial Management

The FSM Title V Program is managed by the FSM National Government, Department of Health and Social Affairs (DHSA), which is located at Palikir on the island of Pohnpei. For the purposes of receiving U. S. Federal Domestic Assistance, the National Government is designated as the "State Agency". However, all funds approved by the U. S. Federal Government to support Title V program and allocated to the FSM Government are further allotted to each State Title V Program by way of Advice of Allotments issued by the National Division of Budget, under the administration of the Department of Finance and Administration. The Title V program employs a Program manager at the National level, and the State Title V programs employ all clinical and non-clinical staffs who are taking care of the management of the Title V programs in their respective States. All MCH clients seeking Title V services in the four FSM States have reported either low incomes or no income at all. The Public Health Department provides all of the preventive and primary health care services at no cost to the clients.

Emergency Preparedness

There is a National Disaster Response Plan established in 2016 for the FSM which is called “Federated States of Micronesia National Disaster Response Plan 2016”. This plan provides for the establishment of national institutional arrangements for the Federated States of Micronesia (FSM) government for responding to emergency and disaster events within the country. It includes arrangements for preparedness, monitoring for potential events and response at the national level to manage national level events and support state level events. It also outlines arrangements to guide state disaster response plans and their connection to the national level arrangements. It includes provisions for accessing international support.

FSM has been the recipient of two cooperative agreements: Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP). The main functions of these cooperative agreements are preparedness and response planning.

When Zika virus was reported in the state of Kosrae, one of four states within the Federated States of Micronesia (FSM), the territory responded with a PHEP-funded mosquito control and elimination campaign. Campaign activities included an island-wide mosquito survey, communication efforts such as travel advisory brochures, radio programs, and posters, and mosquito spraying at the homes of all reported cases.

HPP Capabilities are:
Capability 1: Foundation for Health Care and Medical Readiness
Capability 2: Health Care and Medical Response Coordination
Capability 3: Continuity of Health Care Service Delivery Goal of Capability
Capability 4: Medical Surge

FSM's SITUATION in COVID-19, PREPAREDNESS AND RESPONSE

As of August 16, 2021, there is still no confirmed case of COVID-19 in the Federated States of Micronesia. All countries of the world including the FSM, have benefited from the many guidance documents and recommendations for COVID-19 issued by the WHO, US HHS and US CDC. However, the FSM has found it necessary to adapt some

of the guidance documents and recommendations from these health organizations in order to address our unique islands and cultural settings. The document is called for our own FSM National Guidelines for COVID-19.

Other Issues

The FSM, like many Pacific island countries and territories, face a triple burden including communicable disease, noncommunicable disease, and the health impacts of climate change. Adverse effects of climate change and highly vulnerable nature disaster are areas that the nation is still focusing on for the country and its partners. These natural disasters tore through the islands of the FSM causing fatalities, damaging houses, crops, and public infrastructure, and causing millions of dollars in damage.

As usual, other barriers and challenges that all the MCH programs in the four FSM States do encountered are shared and exist in the MCH population domain. Demographic Setting of the islands is always a challenge, and it has been a major barrier in the healthcare services delivery to the in-need population. Transportation issues either by land or air is very expensive and most families could not afford in the long run. Data collection from hard to reach areas and the Outer Islands is an ongoing issue that the MCH programs are still tackling. All of these existing issues in the MCH programs had been discussed and deliberated upon for better solutions.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

During 2020, the MCH Program conducted a comprehensive FSM-wide needs assessment (NA), an ongoing collaborative process, that is critical to program planning and development and enables FSM to target services and monitor the effectiveness of interventions that support improvements in the health, safety and well-being of the MCH population. It serves as a vital planning process for determining where best to focus efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. The NA requires ongoing sources of information about MCH status, risk factors, access, capacity and outcomes. FSM chose a conceptual framework for the NA process that uses a primary prevention and early intervention-based approach with the goal of optimizing health and well-being among the MCH population across the life course, taking into account the many factors that contribute to health outcomes. FSM developed this view collaboratively by discussing the overall framework with the MCH NA Steering Committee (SC) and by subsequently building consensus for this approach with the MCH staff members.

For purposes of assessment and strategic planning, the MCH population was defined as per the standard domains. The overall goal of the process focused on identifying a set of definite priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based interventions grounded in sound public health theory or research and consistent with the mission and scope of FSM's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process focused on meaningfully involving multiple national, state and community stakeholders/partners to enhance collaboration, while looking for opportunities to coordinate and integrate MCH efforts externally and internally across the MCH continuum.

With leadership from the MCH Coordinator, the MCH Needs Assessment Steering Committee (SC) established the overall strategic direction and methodology for the NA while providing the ongoing project management and oversight for the process. National members of the SC and the NA consultant traveled to each State to conduct individual State NAs. The State meetings were well attended with staff and diverse community members participating. The SC and select State representatives were to meet at the end of March 2020 to finalize the priority needs. Unfortunately, COVID-19 prevented an in-person meeting and this was conducted virtually and through email. This two-part process allowed for individual State input from staff, partners, families, consumers and other key stakeholders into the overall FSM-wide NA.

The SC received support and advice from the State MCH staff. The MCH staff initially provided critical feedback regarding the overall process methodology and later participated in focus groups and/or completed the priority health issues survey. The MCH staff reviewed the priorities prior to submission and will be reconvened after grant funding in order to identify future initiatives.

Stakeholders included representation from national and state MCH programs, family/youth serving agencies, faith-based agencies, and other key MCH community partners such as health care providers and community-based agency staff, along with representatives from other state agencies and academic institutions. Criteria used for selecting stakeholders included their area of expertise and workplace setting, training and experience, knowledge of public health, and their ability to conceptualize at the strategic level, while not solely advocating for a single issue. Members solicited feedback from their own constituencies/ stakeholders in between meetings which greatly expanded the reach of this effort.

FSM assessed the needs of the MCH population using Title V indicators, performance measures and other data. The SC reviewed major morbidity, mortality, health problems, gaps and disparities for the MCH population in order to identify specific needs by MCH population domain based on analysis of data trends. The cross-cutting and systems building needs were also examined. Specifically, the SC reviewed 2015 NA and interim NA findings and noted

trends since the last assessment, recent state, regional and national reports to determine possible issues/problems to be explored in the FSM, and recommendations made by various task forces; identified major data/indicators including trends of health status, access, health needs and health disparities to be included in the assessment for each domain; and determined stakeholder and public input processes. Methods used for assessing needs for each of the population domains included a review of the various data sources including Vital Statistics Data, Census Data, FSM Behavioral Risk Factor Surveillance System (BRFSS) Report, Surveillance Systems and Registries, Mortality Reviews, and other FSM agency data and reports.

During 2021, the FSM National and State MCH Program Coordinators and key staff met, virtually, on three (3) separate occasions to further systematically assess needs of the various MCH populations. The reassessment of the MCH population needs was part of the ongoing annual need assessment process as well as FSM's response to the recommendations made based on the challenges cited in the 2021 Grant Application and provided in the 2020 MCH Block Grant Review Summary Statement. Acting on feedbacks provided in the 2020 MCH Block Grant Review Summary Statement, a requested for Technical Assistance (TA) Training was submitted to the MCH Bureau. Most of the challenges noted in the Review Summary Statement had to do with the FSM 2021 State Action Plan development. Some of the weaknesses as cited included the following; "many strategies and evidence-based or –informed measures (ESMs) are focused on health promotion, patient education, one-on-one health care provider and patient interactions, and provider training and education, which may not be effective strategies in showing improvements in data trends". "Denominator values vary across many National Performance Measures (NPMs), ESMs, and State Performance Measures (SPMs), and limited information is included in the field notes to explain the drastic changes in denominators from year to year. Therefore, data trends are difficult to evaluate, which makes it difficult to measure program success", etc. "The FSM Title V MCH Program is encouraged to request technical assistance to improve the alignment and effectiveness of priorities, strategies, NPMs, SPMs, and ESMs". A Technical Assistance (TA) Training was authorized for FSM and Dr. Haley Cash conducted a Virtual TA Training on May 18, 20, 25 and 26, 2021. The TA Sessions were two hours long, each, and attended by the National and State MCH Program Coordinators and key staff.

The TA sessions were combination of: 1) slide presentations given by the Consultant on the MCH Bureau and Block Grant Program Requirements; 2) review of the FSM 2021 Grant Application Action Plan focusing on the State Priorities and National Performance Measures selected, Strategies, Evidenced-Based Informed Strategic Measures, and State Performance Measures developed, Data Sources, and discussion on how to improve the alignment and effectiveness of priorities, NPMs, Strategies, ESMs and SPMs; and 3) group work by MCH Population Domain by FSM State and next steps.

Again, realizing the dynamic nature of MCH as well as the depth and breadth of issues specific to these populations, FSM will continue to systematically assess needs during the remaining years of the program cycle.

Women/Maternal Health:

All clinical sites within FSM Public Health perform women's preventive health exams. However, in 2020 only 19.0% of MCH women had a Pap smear at these clinical sites. It is important to note that in Pohnpei and Yap visual inspection with acetic acid (VIA) is used as an alternative to Pap testing which is not reflected in the data below. According to the 2018 FSM BRFSS three out of ten female respondents (30.6%) reported that they ever had a pap test or VIA. Even so, the FSM has a very large underserved population who are not receiving recommended annual preventive health services. Many women are not receiving adequate preventive health care. As in many underserved communities with a high percentage of families living below the federal poverty level, these women face many barriers to care, including: unaware of health needs; shame or fear in seeking reproductive health services; access to care issues; uninsured status; transportation issues; and childcare issues. The 2018 FSM BRFSS found that 5.9% of women surveyed reported that in general their health is poor.

Table 1 Percent of women receiving services in the MCH Programs who receive a Pap smear

Percent	2018	2019	2020
FSM:	15.6	51.2%	19.0%
Chuuk:	24.2	36.9%	19.8%
Kosrae:	26.1	46.8%	19.2%
Pohnpei:	8.2	87.1%	18.1%
Yap:	37.0	97%	33.2%

Source: MCH Program Data

Table 2 Percent of women receiving a preventive medical visit

Percent	2018	2019	2020
FSM:	74.0	41.1%	43.9%
Chuuk:	49.1	36.9%	19.8%
Kosrae:	26.1	17.1%	52.3%
Pohnpei:	83.6	45.4%	45.4%
Yap:	37.3	97.0%	93.1%

Source: MCH Program Data

The FSM maternal health clinics serve as many women's first entry into medical care or their medical home. MCH recommends and provides preventive health services in accordance with recognized standards of care. The program aims to improve the number of clients that follow the recommended standard of care in preventive health services through increased education and outreach efforts and collaboration with community-based programs. Because the preventive health clinics of the FSM all exist within the public health facilities, clients can avail themselves of multiple public health screening and preventive services in one visit. In this way, The MCH Program serves as the gateway to care through partnerships with other public health programs. The MCH Program works closely with the Family Planning Program, Tobacco Control Program, STD/HIV Prevention Program, and other health and social programs. Once again, clients need not make multiple appointments or visit multiple clinics to participate in these program services, thereby allowing for comprehensive and cohesive preventive health care.

An assessment of prenatal care conducted at the hospitals in the FSM showed that almost 51% of deliveries receive inadequate prenatal care often due to late entry into care. In addition, some FSM states estimated up to 10% of deliveries received no prenatal care at all. MCH Program continues to strive to improve prenatal care adequacy. The process of prenatal care at the clinic may be a deterrent to some women. Prenatal care is only offered on certain clinic days and not by appointment. This means there is limited availability of services that women may have difficulty fitting into their schedules. It also means long wait times in crowded waiting rooms. Besides wait time, the process of being seen is still long as there are many steps to the visit. In some locations, the woman must check in at one location, see the provider at another, then go to a third location for lab draws and a fourth location for the dental check. Streamlining the process may increase prenatal care attendance.

Table 3 Percent of pregnant women who receive prenatal care beginning in the first trimester

Percent	2018	2019	2020
FSM:	30.6	27.6	33.5
Chuuk:	20.7	21.0	26.6
Kosrae:	31.6	24.0	29.8
Pohnpei:	43.4	37.6	43.4
Yap:	27.7	23.1	23.3

Source: MCH Program Data

Even amongst those seeking prenatal care, that care is not always adequate. There is limited pregnancy expectation education so the community is unaware of what to anticipate during pregnancy and prenatal care. During prenatal

care, only Kosrae does routine glucose tolerance testing to screen for gestational diabetes. Pohnpei, Yap and Chuuk do screening based on risk assessment of known history of diabetes or gestational diabetes. In speaking with pediatric providers in the FSM, all report treating many infants with difficulty controlling their blood sugar within the first 48 hours after birth, a telltale sign of missed or poorly control gestational diabetes.

Perinatal/Infant Health:
The perinatal mortality rate in the FSM in 2020 was 39.7 per 1,000 live births but even that is low comparing the past four years. The MCH Program is committed to improving prenatal care access and adequacy as stated above through the MCH clinics and dispensaries in remote villages.

Table 4 Perinatal mortality rate per 1,000 live births plus fetal deaths

Rate	2018	2019	2020
FSM:	18.2	28.3	39.7
Chuuk:	28.6	26.8	58.9
Kosrae:	37.3	24.0	25.9
Pohnpei:	1.4	29.2	29.2
Yap:	20.3	33.2	23.4

Source: Vital Statistics

In 2020, 73.5% of mothers in FSM report exclusively breastfeeding their child at six months of age. Although this is a high percentage, of those that supplement, the supplements are not a healthy alternative but often coconut milk. Education needs to be provided to mothers on breastfeeding and infant nutrition. Currently childcare education is lacking in the FSM. New mothers rely on families to inform them about child care and rearing and this is not always the healthiest or safest information. Anemia is prevalent in the infant population of FSM as well as the childbearing woman population as discussed above. In 2020, 9% of infants up to 1 year old screened were anemic. The MCH Program continues to screen infants for anemia due to the high prevalence among the population.

The current 2021 NPM (Percent of very low birth weight infants born in a hospital with a Level III+ neonatal Intensive Care unit (NICU)) does not meet the situation in the FSM as none of the FSM state Hospital has NICU. Further, the NPM does not really relate to the priority, as the priority is aiming at early and adequate prenatal care while the NPM is focused on neonatal care. Therefore, several issues were discussed to address the state needs and priority. Additionally, because the new NPM only addresses one area in the priority (early and adequate prenatal care) the group thought a second SPM should be established to address the other need in the priority: (To include gestational diabetes in the routine prenatal care and ensuring that all women are screened by 24-28weeks gestation). The current ESM in 2021 (the percent of community clinics with extended service hours offering services to facilitate access to preventative visits) not only does it not correlate to the NMP and Priority, it also is something that MCH and the DHS have no direct control over. Community clinics are another entity with their own mandates. Therefore, strategies are created to properly address these needs of NPM and Priority:

Child Health:
Immunizations are a pillar of child health care. The overall coverage rates of immunization in FSM has improved significantly. Once of the main barriers to immunizations in the FSM is the need for refrigeration of the vaccines, thereby making it difficult to provide to children of the outer and remote islands. This is apparent in the Kosrae specific data. Kosrae is a single island State. In this State without outer and remote islands coverage is consistently greater than 90%. In Pohnpei and Yap, outreach and services to the outer islands is only done once or twice a year and the schedule is often dependent on having fuel for the boat. FSM MCH Program plans to hold gains and improve immunizations through education and outreach.

Table 5 Percent of children through age 2 who have completed routine immunizations

Percent	2018	2019	2020
FSM:	86.4	51.2	68.4
Chuuk:	96.4	34.5	66.5
Kosrae:	90.0	95.9	87.7
Pohnpei:	64.2	66.9	66.9
Yap:	67.4	61.4	79.0

Source: FSM Immunization Program

Unfortunately, post WWII with the introduction of western culture, locals began eating processed foods such as canned meats and rice. This diet has been integrated into the culture of the locals and is considered “traditional food”. Processed foods are affordable and plentiful in this remote area where fresh ingredients are often hard to come by, perishable, and expensive for the average FSM resident. This highly processed diet in a population with a strong genetic propensity to diabetes and hypertension leads to devastating rates of diabetes, heart disease, stroke, renal failure and dialysis in patients much younger than the average age in the US mainland. FSM MCH Program intends to start young to combat obesity and nutrition to prevent non-communicable diseases.

Table 6 Percent of children overweight/obese, 2020?

Percent	2018	2019	2020
FSM	4.1	4.3	2.9
Chuuk	3.6	1.5	1.0
Kosrae	3.3	32.5	1.0
Pohnpei	1.6	2.7	2.7
Yap	52.2	8.1	11.4

Source: FSM Youth NCD Risk Factors Report

Currently developmental screenings are only completed on the MCH population but not the population at large. In 2020, only 9.1% of all children age 0-9 years old were screened for developmental delays. There are no efforts to screen all children through either a provider or parent tool. Current screening tools are developed up until age 18 months. No standardized tool exists beyond that age group. Diagnosis often depends on specialist visits from off island so MCH provides gap care until the next specialist is on island. Interventions for those with delays do not begin until age 3 with Special Education, therefore the MCH program provides gap care for these children as well.

Adolescent Health:
The FSM teen birth rate among 15-17 year-olds for 2020 was 31.4 births per 1,000 females, which is about five times greater the national average of 7.2 as reported by the CDC National Center for Health Statistics. This population has not followed the US trend towards delaying childbearing. Some progress has been made in delaying age of consent. Just five years ago, Chuuk increased the legal age of consent from 13 to 18 years old. In 2018, Yap increased the legal age of consent from 13 to 16 years old. And just last year, Pohnpei passed its first age of consent law at 18 years old.

Table 7 Rate of birth (per 1,000) for teenagers aged 15-17 years

Rate	2018	2019	2020
FSM:	64.6	36	31.4
Chuuk:	74.4	37.5	27.2
Kosrae:	32.7	14.3	43.5
Pohnpei:	64.4	40.6	40.6
Yap:	24.2	26.5	12.1

Source: FSM Birth Certificate and Census Data

Teen births increase health risks to both mother and child including low birth weight, preterm birth, and death in

infancy. In addition to health risks teen births set up a cycle of disadvantages. Teen mothers are less likely to finish high school and their children are more likely to have low school achievement, drop out of high school, and give birth themselves as teens. For these reason MCH Program works closely with the FSM Dept of Education to prevent teen pregnancy. Clinic locations are at High Schools and the college. Condoms are available at many community locations. The rate of sexually transmitted diseases (STDs) in the FSM is improving.

	2018	2019	2020
Annual Rate:	16.5	19.1	62.0

Table 8 Rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

Source: STD Program

The MCH goal is to encourage positive health behavior activity in adolescents, through comprehensive interventions at age-appropriate levels in a culturally-sensitive manner that will impact the frightening possibilities of adolescent risk behavior activity, including, but not limited to: unplanned pregnancy and teen birth; sexually transmitted diseases in the adolescent and young adult population; alcohol use; and drug use. The MCH Program currently works and will continue to work with youth groups in each State to reach the adolescent population.

Risky adolescent behavior such as drug and alcohol use lead to injury such as motor vehicle crashes. Adolescent motor vehicle mortality rate, ages 15 through 19 was 8.9 per 100,000 in 2020. Although not much data exists on current drug and alcohol use, it is believed throughout the community that the use does exist and influences poor outcomes. In 2017, the FSM Youth NCD Risk Factors survey measured alcohol use prevalence. 30.7% of high school students in the FSM reported using alcohol in the past 30 days. Results were highest among males, in the 11th and 12th grade and in Yap State. There is lack of law enforcement surrounding alcohol sales and many businesses in the FSM sell alcohol cheap and to youth. Additionally, in the FSM there is a cultural norm to drink sakau, a sedative agent derived from the roots of a shrub, pounded and mixed with water. This is done both ceremoniously in traditional customs and socially. There is no age limit on drinking sakau and is drank increasingly by the youth.

Teen suicide is an issue in FSM with a rate as high as 17.8/100,000 adolescents being reported in 2020. More awareness and education around suicide, its causes and prevention is necessary in the FSM.

Table 9 Rate per 100,000 of suicide deaths among youths aged 15 through 19 years

Rate	2018	2019	2020
FSM:	17.5	8.8	17.8

Source: Vital Statistics

Currently the FSM MCH program provides school physicals until age 12 but not again unless required for college entry. As such, well adolescent visits do not occur with regularity. The Program plans to expand these school physicals into the high school grades. During these well adolescent visits, youth will receive assessment on violence and safety and information and education on risky behavior and its possible negative outcomes.

The FSM MCH programs currently agreed to develop a new SPM for the adolescent domain because the priority area was not fully addressed by the current NPM 10 (***Percent of adolescents ages 12-17, with a preventive medical visit in the past year)*** which FSM recently had selected in the initial 5 years needs assessment plan**.** The NPM 10 is not achievable due to no population-based surveys or any data reports available that is directly collecting reporting on NPM10. So, FSM team came up with an SPM; ***Percent of adolescents aged 12-17 years old who have attended educational awareness sessions on adolescent behavioral health in the schools***, which is believed to be more realistic and achievable in the FSM. The Numerator is ***Number of 12-17 years who have attended educational awareness sessions on adolescent behavioral health and risk behavior in the***

schools and the Denominator is ***total number of adolescents (12-17 years old) in the state.*** The new SPM will be implemented in the 2022 plan in order to help redirect the focus of MCH programs resources and activities into this selected indicator,

Children with Special Health Care Needs:
The Program tracks percent of children identified with a special health care need that are part of the CSHCN Program. In 2020, only 9.1% of children were screened for developmental delays. However, of those identified, 81% of children with developmental delays were receiving services according to 2020 data.

Table 10 Percent of CSHCN

Percent	2018	2019	2020
FSM:	4.7	4.5	4.4

Source: CSHCN Program

Most children in the program are identified through Child Find a program of Special Education, when diagnosed as deaf or hard of hearing, or seen and referred by Shriners during Shriners annual visit. Diagnosis often depends on specialist visits from off island so MCH provides gap care until the next specialist is on island. Interventions for those with delays do not begin until age 3 with Special Education, therefore the MCH program provides gap care for these children as well. Transitional services for CSHCN are tracked through the CSHCN Survey using a proxy measure of employment.

Table 11 Percent of youth with special health care needs who are employed as a proxy for receiving the services necessary to make transition to all aspects of adult life, including health care, work and independence.

Percent	2018	2019	2020
FSM:	1.4	1.5	1.7

Source: Special Education

The CSHCN Program in FSM relies heavily upon its partnership with the Special Education. Although the strong relationship is an asset, the CSHCN Program needs to do more distinct work with their population, including providing care coordination and transitional services.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The comprehensive FSM-wide needs assessment (NA) is an ongoing collaborative process, that is critical to program planning and development and enables FSM to target services and monitor the effectiveness of interventions that support improvements in the health, safety and well-being of the MCH population. It serves as a vital planning process for determining where best to focus efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. The NA requires ongoing sources of information about MCH status, risk factors, access, capacity and outcomes. FSM chose a conceptual framework for the NA process that uses a primary prevention and early intervention-based approach with the goal of optimizing health and well-being among the MCH population across the life course, taking into account the many factors that contribute to health outcomes. FSM developed this view collaboratively by discussing the overall framework with the MCH NA Steering Committee (SC) and by subsequently building consensus for this approach with the MCH staff members.

For purposes of assessment and strategic planning, the MCH population was defined as per the standard domains. The overall goal of the process focused on identifying a set of definite priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based interventions grounded in sound public health theory or research and consistent with the mission and scope of FSM's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process focused on meaningfully involving multiple national, state and community stakeholders/partners to enhance collaboration, while looking for opportunities to coordinate and integrate MCH efforts externally and internally across the MCH continuum.

With leadership from the MCH Coordinator, the MCH NA SC established the overall strategic direction and methodology for the NA while providing the ongoing project management and oversight for the process. From September to December 2019, National members of the SC and the NA consultant traveled to each State to conduct individual State NAs. The State meetings were well attended with staff and diverse community members participating. The SC and select State representatives were to meet in Pohnpei at the end of March 2020 to finalize the priority needs. Unfortunately, COVID-19 prevented an in-person meeting and this was conducted virtually and through email. This two part process allowed for individual State input from staff, partners, families, consumers and other key stakeholders into the overall FSM-wide NA.

The SC received support and advice from the State MCH staff. The MCH staff initially provided critical feedback regarding the overall process methodology and later participated in focus groups and/or completed the priority health issues survey. The MCH staff reviewed the priorities prior to submission and will be reconvened after grant funding in order to identify future initiatives.

Stakeholders included representation from national and state MCH programs, family/youth serving agencies, faith-based agencies, and other key MCH community partners such as health care providers and community-based agency staff, along with representatives from other state agencies and academic institutions. Criteria used for selecting stakeholders included their area of expertise and workplace setting, training and experience, knowledge of public health, and their ability to conceptualize at the strategic level, while not solely advocating for a single issue. Members solicited feedback from their own constituencies/ stakeholders in between meetings which greatly expanded the reach of this effort.

FSM assessed the needs of the MCH population using Title V indicators, performance measures and other data. The SC reviewed major morbidity, mortality, health problems, gaps and disparities for the MCH population in order to identify specific needs by MCH population domain based on analysis of data trends. The cross-cutting and systems building needs were also examined. Specifically, the SC reviewed 2015 NA and interim NA findings and noted trends since the last assessment, recent state, regional and national reports to determine possible issues/problems to be explored in the FSM, and recommendations made by various task forces; identified major data/indicators including trends of health status, access, health needs and health disparities to be included in the assessment for each domain; and determined stakeholder and public input processes. Methods used for assessing needs for each of the population domains included a review of various the data sources including Vital Statistics Data, Census Data, FSM Behavioral Risk Factor Surveillance System (BRFSS) Report, Surveillance Systems and Registries, Mortality Reviews, and other FSM agency data and reports.

Findings were also used to populate the MCH Priority Health Issues Survey. MCH received 139 completed surveys covering

the six domains. Survey participants chose their top three issues for each domain, while also identifying any important issues not reflected in the original list. Of the new issues identified, most had been considered by the SC in earlier phases of the NA process.

Prioritization criteria of potential issues included considering them in terms of the MCH/public health role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using specific indicators to measure progress. A Strengths, Weaknesses, Opportunities and Threats analysis was conducted on each identified priority. To gauge capacity, public health management and staff were asked to assess their organizational capacity to address the potential MCH priority areas. The following four components were utilized to assess capacity for each of the proposed MCH priorities. 1) Structural Resources: Financial, human, and material resources; policies and protocols; and other resources needed for the performance of core functions. 2) Data/Information Systems: Access to timely program and population data; supportive environment for data sharing; adequate technological resources to support the use of data in decision-making. 3) Competencies/Skills: Knowledge, skills, and abilities of MCH staff. 4) Organizational Relationships: Partnerships, communication channels, and other types of interactions and collaborations with public and private entities. Next, each issue was ranked, using a grid specifying impact and feasibility along an x and y axis. These elements served as key resources for discussion in determining the final set of priorities.

In keeping with the guiding principles of the process, the SC focused on the goal of identifying select areas for MCH investment within its scope of influence, so that a comprehensive set of interventions could be employed at more depth to affect five-year outcomes. In order to do so, the SC was charged with connecting each potential priority to a national or population-based outcome measure. To this end, the SC prepared a justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue; and specific indicators that could be used to measure success within the five-year period.

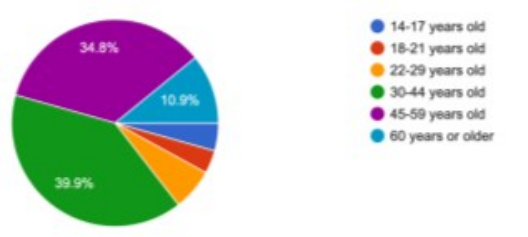
Realizing the dynamic nature of MCH as well as the depth and breadth of issues specific to these populations, FSM will continue to systematically assess needs during the upcoming five-year time frame.

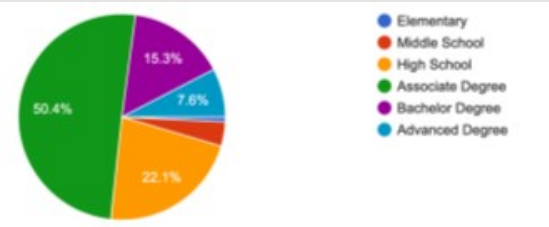
III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

One hundred and thirty nine (139) surveys were received. Responses were received from respondents who reside in all four islands of the FSM. The majority, 71%, of respondents were female. Respondents accurately reflected all ages and educational levels in the FSM. Furthermore, 30.9% or 43 Parents/Guardians completed the survey the highest of any identified role. Other roles were Community Service Provider, Health Care Professional, Public Health Employee, Educator, Child Care Provider/Caregiver, Policy Maker/Elected Official and Other Community Member.

Figure 1. Survey Demographics for Age and Highest Level of Education





Women/Maternal Health:

All clinical sites within FSM Public Health perform women's preventive health exams. However, in 2018 only 15.6% of MCH women had a Pap smear at these clinical sites. It is important to note that in Pohnpei and Yap visual inspection with acetic acid (VIA) is used as an alternative to Pap testing which is not reflected in the data below. According to the 2018 FSM

BRFSS three out of ten female respondents (30.6%) reported that they ever had a pap test or VIA. Even so, the FSM has a very large underserved population who are not receiving recommended annual preventive health services. Many women are not receiving adequate preventive health care. As in many underserved communities with a high percentage of families living below the federal poverty level, these women face many barriers to care, including: unaware of health needs; shame or fear in seeking reproductive health services; access to care issues; uninsured status; transportation issues; and childcare issues. The 2018 FSM BRFSS found that 5.9% of women surveyed reported that in general their health is poor.

Table 1 Percent of women receiving services in the MCH Programs who receive a Pap smear

Percent	2015	2016	2017	2018
FSM:	25.8	26.0	21.6	15.6
Chuuk:	27.9	40.1	34.0	24.2
Kosrae:	60.5	39.5	51.7	26.1
Pohnpei:	16.0	13.6	15.7	8.2
Yap:	39.5	40.0	17.0	37.0

Source: MCH Program Data

Table 2 Percent of women receiving a preventive medical visit

Percent	2016	2017	2018
FSM:	17.9	76.3	74.0
Chuuk:	13.7	34.0	49.1
Kosrae:	28.8	56.5	26.1
Pohnpei:	18.3	91.4	83.6
Yap:	25.9	56.6	37.3

Source: MCH Program Data

The FSM maternal health clinics serve as many women's first entry into medical care or their medical home. MCH recommends and provides preventive health services in accordance with recognized standards of care. The program aims to improve the number of clients that follow the recommended standard of care in preventive health services through increased education and outreach efforts and collaboration with community-based programs. Because the preventive health clinics of the FSM all exist within the public health facilities, clients can avail themselves of multiple public health screening and preventive services in one visit. In this way, The MCH Program serves as the gateway to care through partnerships with other public health programs. The MCH Program works closely with the Family Planning Program, Tobacco Control Program, STD/HIV Prevention Program, and other health and social programs. Once again, clients need not make multiple appointments or visit multiple clinics to participate in these program services, thereby allowing for comprehensive and cohesive preventive health care.

An assessment of prenatal care conducted at the hospitals in the FSM showed that almost 70% of deliveries receive inadequate prenatal care often due to late entry into care. In addition, some FSM states report up to 10% of deliveries received no prenatal care at all. MCH Program continues to strive to improve prenatal care adequacy. The process of prenatal care at the clinic may be a deterrent to some women. Prenatal care is only offered on certain clinic days and not by appointment. This means there is limited availability of services that women may have difficulty fitting into their schedules. It also means long wait times in crowded waiting rooms. Besides wait time, the process of being seen is still long as there are many steps to the visit. In some locations, the woman must check in at one location, see the provider at another, then go to a third location for lab draws and a fourth location for the dental check. Streamlining the process may increase prenatal care attendance.

Table 3 Percent of pregnant women who receive prenatal care beginning in the first trimester

Percent	2015	2016	2017	2018
FSM:	23.3	31.0	41.2	30.6
Chuuk:	14.0	28.9	26.2	20.7
Kosrae:	29.6	28.8	33.8	31.6
Pohnpei:	35.5	35.5	65.4	43.4
Yap:	25.9	25.9	27.7	27.7

Source: MCH Program Data

Even amongst those seeking prenatal care, that care is not always adequate. There is limited pregnancy expectation education so the community is unaware of what to anticipate during pregnancy and prenatal care. During prenatal care, only Kosrae does routine glucose tolerance testing to screen for gestational diabetes. Pohnpei, Yap and Chuuk do screening based on risk assessment of known history of diabetes or gestational diabetes. In speaking with pediatric providers in the FSM, all report treating many infants with difficulty controlling their blood sugar within the first 48 hours after birth, a telltale sign of missed or poorly control gestational diabetes.

In 2010, the FSM MCH Program noticed an increase in women being diagnosed with anemia during pregnancy. In an effort to increase a woman's health status prior to pregnancy the program instituted screening of all women for anemia not just pregnant women. In 2018, 21.6% of women of childbearing age screened had anemia. Anemia screening and treatment is still a necessary measure of all women in the FSM.

Perinatal/Infant Health:
The perinatal mortality rate in the FSM in 2018 was 18.2 per 1,000 live births but even that is low comparing the past four years. According to the National Vital Statistics Reports, the most recent national perinatal mortality rate available was 6.00 per 1,000 live births in 2016. When this data is coupled with the 2018 low birth weight percentage of 7.8% of live singleton births a scenario begins to form in which unplanned pregnancy, late access and inadequate prenatal care, and poverty play a significant role in poor birth outcomes, causing additional stressors on the family, community, the health care system and the government. As discussed above, lack of screening for gestational diabetes during prenatal care effects newborn outcomes. The MCH Program is committed to improving prenatal care access and adequacy as stated above through the MCH clinics and dispensaries in remote villages.

Table 4 Perinatal mortality rate per 1,000 live births plus fetal deaths

Rate	2015	2016	2017	2018
FSM:	28.7	41.1	26.6	18.2
Chuuk:	37.1	34.4	39.3	28.6
Kosrae:	7.0	7.5	15.2	37.3
Pohnpei:	22.2	56.1	15.2	1.4
Yap:	25.8	34.1	18.2	20.3

Source: Vital Statistics

In 2018, 76.4% of mothers in FSM report exclusively breastfeeding their child at six months of age. Although this is a high percentage, of those that supplement, the supplements are not a healthy alternative but often coconut milk. Education needs to be provided to mothers on breastfeeding and infant nutrition. Currently childcare education is lacking in the FSM. New mothers rely on families to inform them about child care and rearing and this is not always the healthiest or safest information. Anemia is prevalent in the infant population of FSM as well as the childbearing woman population as discussed above. In 2018, 14.4% of infants up to 1 year old screened were anemic. The MCH Program continues to screen infants for anemia due to the high prevalence among the population.

Child Health:
Immunizations are a pillar of child health care. The overall coverage rates of immunization in FSM has improved significantly. Once of the main barriers to immunizations in the FSM is the need for refrigeration of the vaccines, thereby making it difficult to provide to children of the outer and remote islands. This is apparent in the Kosrae specific data. Kosrae is a single island State. In this State without outer and remote islands coverage is consistently greater than 90%. In Pohnpei and Yap, outreach and services to the outer islands is only done once or twice a year and the schedule is often dependent on having fuel for the boat. FSM MCH Program plans to hold gains and improve immunizations through education and outreach.

Table 5 Percent of children through age 2 who have completed routine immunizations

Percent	2015	2016	2017	2018
FSM:	62.7	54.9	59.5	86.4
Chuuk:	33.9	37.4	44.4	96.4
Kosrae:	95.2	93.6	95.2	90.0
Pohnpei:	80.8	65.9	69.8	64.2
Yap:	93.8	93.1	81.4	67.4

Source: FSM Immunization Program

FSM children experience a high rate of being overweight 20.5% as compared to the US, 15.6% both in 2017. Unfortunately, post WWII with the introduction of western culture, locals began eating processed foods such as canned meats and rice. This diet has been integrated into the culture of the locals and is considered “traditional food”. Processed foods are affordable and plentiful in this remote area where fresh ingredients are often hard to come by, perishable, and expensive for the average FSM resident. This highly processed diet in a population with a strong genetic propensity to diabetes and hypertension leads to devastating rates of diabetes, heart disease, stroke, renal failure and dialysis in patients much younger than the average age in the US mainland. FSM MCH Program intends to start young to combat obesity and nutrition to prevent non-communicable diseases.

Table 6 Percent of children overweight/obese, 2017

	Chuuk	Kosrae	Pohnpei	Yap	FSM
Percent	40.4	38.1	32.6	33.4	35.4

Source: FSM Youth NCD Risk Factors Report

Currently developmental screenings are only completed on the MCH population but not the population at large. In 2018, only 8.2% of all children age 0-9 years old were screened for developmental delays. There are no efforts to screen all children through either a provider or parent tool. Current screening tools are developed up until age 18 months. No standardized tool exists beyond that age group. Diagnosis often depends on specialist visits from off island so MCH provides gap care until the next specialist is on island. Interventions for those with delays do not begin until age 3 with Special Education, therefore the MCH program provides gap care for these children as well.

Adolescent Health:
The FSM teen birth rate among 15-17 year olds for 2018 was 64.6 births per 1,000 females, which is nine times greater the national average of 7.2 as reported by the CDC National Center for Health Statistics. This population has not followed the US trend towards delaying childbearing. Some progress has been made in delaying age of consent. Just five years ago, Chuuk increased the legal age of consent from 13 to 18 years old. In 2018, Yap increased the legal age of consent from 13 to 16 years old. And just last year, Pohnpei passed its first age of consent law at 18 years old.

Table 7 Rate of birth (per 1,000) for teenagers aged 15-17 years

Rate	2015	2016	2017	2018
FSM:	18.3	21.2	24.2	64.6
Chuuk:	18.0	21.6	24.3	74.4
Kosrae:	0.0	7.9	0.0	32.7
Pohnpei:	20.5	22.3	35.6	64.4
Yap:	25.0	24.8	11.3	24.2

Source: FSM Birth Certificate and Census Data

Teen births increase health risks to both mother and child including low birth weight, preterm birth, and death in infancy. In addition to health risks teen births set up a cycle of disadvantages. Teen mothers are less likely to finish high school and their children are more likely to have low school achievement, drop out of high school, and give birth themselves as teens. For these reason MCH Program works closely with the FSM Dept of Education to prevent teen pregnancy. Clinic locations are at High Schools and the college. Condoms are available at many community locations. The rate of sexually transmitted diseases (STDs) in the FSM is improving.

	2015	2016	2017	2018
Annual Rate:	20.6	4.3	6.0	16.5

Table 8 Rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia

Source: STD Program

The MCH goal is to encourage positive health behavior activity in adolescents, through comprehensive interventions at age-appropriate levels in a culturally-sensitive manner that will impact the frightening possibilities of adolescent risk behavior activity, including, but not limited to: unplanned pregnancy and teen birth; sexually transmitted diseases in the adolescent and young adult population; alcohol use; and drug use. The MCH Program currently works and will continue to work with youth groups in each State to reach the adolescent population.

Risky adolescent behavior such as drug and alcohol use lead to injury such as motor vehicle crashes. Adolescent motor

vehicle mortality rate, ages 15 through 19 was 17.3 per 100,000 in 2018. Although not much data exists on current drug and alcohol use, it is believed throughout the community that the use does exist and influences poor outcomes. In 2017, the FSM Youth NCD Risk Factors survey measured alcohol use prevalence. 30.7% of high school students in the FSM reported using alcohol in the past 30 days. Results were highest among males, in the 11^{th} and 12^{th} grade and in Yap State. There is lack of law enforcement surrounding alcohol sales and many businesses in the FSM sell alcohol cheap and to youth. Additionally, in the FSM there is a cultural norm to drink sakau, a sedative agent derived from the roots of a shrub, pounded and mixed with water. This is done both ceremoniously in traditional customs and socially. There is no age limit on drinking sakau and is drank increasingly by the youth.

Table 9 Rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

Rate	2015	2016	2017	2018
FSM:	52.4	35.5	57.8	28.8

Source: Hospital Discharge Records

Teen suicide is an issue in FSM with a rate as high as 33.6/100,000 adolescents being reported in 2016. More awareness and education around suicide, its causes and prevention is necessary in the FSM.

Table 10 Rate per 100,000 of suicide deaths among youths aged 15 through 19 years

Rate	2015	2016	2017	2018
FSM:	24.9	33.6	0.0	17.5

Source: Vital Statistics

Currently the FSM MCH program provides school physicals until age 12 but not again unless required for college entry. As such, well adolescent visits do not occur with regularity. The Program plans to expand these school physicals into the high school grades. During these well adolescent visits, youth will receive assessment on violence and safety and information and education on risky behavior and its possible negative outcomes.

Children with Special Health Care Needs:
The Program tracks percent of children identified with a special health care need that are part of the CSHCN Program. In 2018, only 8.2% of children were screened for developmental delays. However, of those identified, 91% of children with developmental delays were receiving services according to 2018 data.

Table 11 Percent of CSHCN

Percent	2015	2016	2017	2018
FSM:	7.5	4.7	5.6	4.7

Source: CSHCN Program

Most children in the program are identified through Child Find a program of Special Education, when diagnosed as deaf or hard of hearing, or seen and referred by Shriners during Shriners annual visit. Diagnosis often depends on specialist visits from off island so MCH provides gap care until the next specialist is on island. Interventions for those with delays do not begin until age 3 with Special Education, therefore the MCH program provides gap care for these children as well. Transitional services for CSHCN are tracked through the CSHCN Survey using a proxy measure of employment.

Table 12 Percent of youth with special health care needs who are employed as a proxy for receiving the services necessary to make transition to all aspects of adult life, including health care, work and independence.

Percent	2015	2016	2017	2018
FSM:	18.6	2.4	5.5	1.4

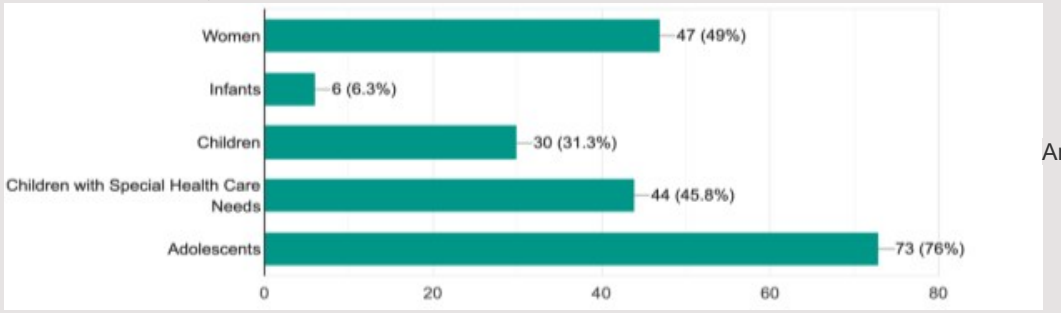
Source: Special Education

The CSHCN Program in FSM relies heavily upon its partnership with the Special Education. Although the strong relationship is an asset, the CSHCN Program needs to do more distinct work with their population, including providing care coordination and transitional services.

Cross-cutting/Systems Building:
Behavioral/mental health is recognized as a need across populations. In the 2018 FSM BRFSS one out of ten individual respondents (10.6%) mentioned that they had 14 or more mentally unhealthy days during the previous 30 days. Additionally, the percentage of respondents who have diagnosed depressive disorder was 7.3%. Furthermore, 94% of NA survey respondents reported mental and behavioral health as a concern. Of those three-fourths believe it is a concern for

adolescents, half believe it is a concern for women and CSHCN, and about one-third believe it is a concern for children. Unfortunately, behavioral/mental health treatment services are lacking in the FSM.

Figure 2. Survey Responses to “What populations need mental and behavioral health services most in your community? (Select all that apply)”



An identified area of need is for screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues to be incorporated into mental health related activities across all domains. Special emphasis would be placed on behavioral health screening during the well-woman visit, during prenatal care visits and during the adolescent well visit.

Impeding priorities in families’ life creates challenges and barriers in seeking preventative health screenings. Poor health literacy contributes to not seeking preventive health services as individuals may not understand the connection of prevention in relation to their general health. The MCH Program has to be in the forefront of providing guidance to communicate the importance and availability of health services throughout the lifespan including healthy behaviors and resources.

A systems building finding is the need for stronger National oversight. Although there is some advantage to the National Program level allowing the State Programs to implement MCH according to their specific needs, this results in a disjointed program. The MCH Program needs to develop guidance through policies and procedures for basic MCH initiatives. In addition, it would be wise for MCH National to develop common educational messages for their communities to be shared by the State Programs. These initiatives can help produce the unity, organization and consistency that is currently lacking while still allowing for some individualization on certain provisions of the program.

An additional systems building need is for improved data collection. The reliability and validity of the data collected by the States and reported to the National MCH Program is questionable. This can be seen in much of the data presented above. The data reported from year to year is quite variable without any justification for the severe fluctuations. FSM has engaged a developer for the establishment of an MCH web-based data collection and reporting system to be launched in 2022. The system should improve data collection, reporting, and sharing at State level and between the States and the National level. This should dramatically improve timely data collection and reporting and improve the overall experience of the FSM MCH Program to better understand the current situation as well as monitor change over time and evaluate activities meant to improve MCH population health.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

There are two levels of government in the FSM, National and State. The FSM is self-governing with locally elected President, Vice President and Congress at the National level. Each State also elects a Governor, Lieutenant Governor, and Legislature. For the purposes of receiving US Federal Domestic Assistance, the National Government is designated as the "State Agency". However, all funds approved by the US Federal Government to support MCH Title V and allocated to the FSM Government are further allotted to each State MCH Program by way of Allotment Advices issued by the National Budget Office.

At the National level, the Secretary of the Department of Health and Social Affairs (H&SA) manages health affairs for the nation. There are several divisions under H&SA, including the Division of Health Services which houses the Family Health Services Section. The MCH Program is one of the six programs under the Family Health Services Section. The Program Manager of the Family Health Services Section also acts as the National MCH Program Coordinator.

The National MCH Coordinator works in collaboration with other coordinators at the national level. The administration and management of the Title V Program is under the direct control of the National MCH Coordinator, who provides guidance and works closely with each of the four state MCH Coordinators. For the planning, implementation and provision of direct services to the MCH populations, each state has an MCH Coordinator.

Health services in the FSM are designed and delivered at the State level. At the State level, the Dept of Health Services is headed by the Director of Health, who is appointed by the Governor of the State and is responsible for all medical and health services in the state. Each state has a central State Hospital with medical, nursing, and support personnel that provide inpatient and outpatient medical services for the residents of the State.

III.C.2.b.ii.b. Agency Capacity

The FSM MCH Programs provides primary care and preventive services to all MCH population domains. The Dept of Health Services provides all of the preventive and primary health care services at no cost to the clients. Teams of physicians and nurses travel to the remote islands to provide screening services.

The staff of the MCH Programs work closely with the staff from other programs to provide the full array of services. The collaboration with other Public Health programs and community partners makes it possible to provide health services. The work is supplemented by enabling services including outreach, case management, educational materials, and transportation to MCH target populations. Below is a description of capacity by domain.

Women/Maternal Health:
Pregnant women are eligible for free of charge direct health care services include the basic and routine high-risk prenatal care. Unfortunately, due to limited clinic space, women/maternal health care is only available at each State clinic on select days.

Prenatal care is provided at each of the State's Dept of Health Services clinic by general physicians or OB/GYNs. For States with neighboring, outer or remote islands, services are provided by Health Assistants at the dispensaries, although women are encouraged to come to the clinic for the first prenatal visit. There are OB/GYNs at each State Hospital for referrals of high risk cases such as diabetes and hypertension. Increasing the percentage of women receiving adequate prenatal care visits, especially during first trimester, continues to be a focus for the MCH Program. Postpartum clinic provides assessment of maternal and fetal health after delivery as well as family planning counseling and contraceptives.

The HIV/STD Prevention Program provides pre- and post-testing counseling, partner identification and notification, treatment, and case management. One successful campaign of the MCH Program was to treat all pregnant women for Chlamydia during prenatal care to help reduce the rates of Chlamydia.

Women's Health and Gynecological services are provided at the State clinics. Breast cancer and cervical cancer screening exams such as pap smears and clinical breast exams are provided at no cost to women that meet the program's criteria. In addition, program staff conducts outreach presentations on early detection and prevention including risk factors. Women must travel off island to receive mammograms as no facility in FSM offers them.

Perinatal/Infant Health and Child Health:
Perinatal health is described above. Unfortunately, due to limited clinic space, infant and child health care is only available at each State clinic on select days.

Newborn assessments and breastfeeding support and education for proper technique or identified issues is provided. Well Baby/Child exams are provided at the State clinics free of charge. Services provided 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.

The Immunization Program ensures availability and accessibility of vaccination services at clinics. Supplemental activities are done to provide immunization out in the villages. One of the difficulties with immunization is the need for refrigeration making transportation and storage of vaccines to and on the outer and remote islands a barrier to receiving proper and timely immunizations.

The Newborn Hearing Screening Program has been successfully screening 90% of our babies before hospital discharge. The MCH Program intends to increase efforts to screen newborns delivered at home at entry into the health care system.

The program has been focusing our quality improvement activities to reduce our loss to follow-up numbers. The EHDI surveillance system has been instrumental in identifying babies requiring additional testing.

The Dental Program provides general dentistry services. Oral health for children is focused on prevention through the school sealant and varnish programs.

Adolescent Health:
The adolescent health focus is on the avoidance of risky health behaviors such as drugs, alcohol, and unsafe sex. The MCH Programs works closely with the HIV/STD Program described above. In addition, they collaborate with the Behavioral Health and Wellness (BH&W) Program to promote positive youth behaviors. The BH&W Program 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 Health Care 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 works to ensure that children not only receive specialized health care that they need but that they avail themselves, if qualified, of the different social service programs on island. One priority of the program is to identify these children at the earliest age possible, preferably right after birth. There are care coordinators, special education teachers, and occupational, physical, and speech therapists on staff for all CSHCN. The Program works collaboratively and cooperatively with other 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 MCH Program, the State Hospital, the Special Education Program, and the Early Childhood Education Program.

Diagnostics of those children who failed two out of three hearing screenings are conducted through teleaudiology or a contracted audiology visit. Those children who are confirmed as having hearing loss are treated and referred for Early Intervention services with the Special Education Program.

Each year a Pediatric Cardiology team travels from the Orange County Children's Hospital in Los Angeles, CA to provide Pediatric Cardiology Services. This team travels to the four states to follow-up on identified cases and screen for new cases of children with possible heart diseases. Those children who are identified with heart problems and need medical treatment are provided with medicine. For those you need surgery and cannot be done on island are referred to Trippler Army Hospital in Honolulu, HI. Specialty teams from Canvassback, Trippler Hospital, and Shriner Children Hospital also visit FSM but at a lesser interval, depending on availability of funds by the FSM Dept of Health. These specialized groups provide services in EENT, Orthopedics, and select surgeries. With limited or practically no state-of-the-art medical equipment, compounded with the lack of physicians with specialized skills, FSM is heavily relied on overseas contractors and medical referrals, both of which are very expensive.

III.C.2.b.ii.c. MCH Workforce Capacity

In 2020, there are 23 full-time staff in the four FSM States funded by the Title V Program. Out of the total 23 employees, nine are in Chuuk state; three in Kosrae state; four in Pohnpei state; and seven in Yap state. Of the nine MCH staff in Chuuk state, three are staff nurses, two coordinators, two health assistants, one health educator, and one dental assistant. Out of the total three employees in Kosrae state there is one coordinator, one staff nurse, and one dental nurse. Of the total four staff in Pohnpei state, there is one coordinator, one dental nurse, one staff nurse, and one lab technician. Of the total seven staff in Yap state, there are two coordinators, two staff nurses, two dental nurses and one dental technician. In addition, there are four data specialists funded by the SSDI Program that play integral role in the Title V Program, who work in each State's Vital Statistics and Record Division. These staff constitute the MCH Programs in each of the State Public Health Depts and they directly provide all of the preventive and primary health care services at no cost to clients.

The four MCH Coordinators, at state level, are responsible for assuring that clinical services are provided to pregnant women, infants, children, and CSHCN. All four MCH Coordinators are Registered Nurses. In addition, each of the States provides in its own budget a medical doctor for the MCH Program. Together they are responsible for assuring that clinical services are provided.

At the National level, one MCH Program Coordinator staff is paid by the MCH program. The National Family Planning

Program Coordinator, data manager and financial specialist, although paid for by a different program, also assist the National MCH Program Coordinator in the planning, developing, implementing, and monitoring of MCH program services and activities at the national and state levels on a daily basis. These staff constitutes the core staff at the national level and the National MCH Program Coordinator reports directly to the Secretary of H&SA.

The FSM MCH Program invites parents of CSHCNs to workshops and conferences in the FSM where they present their experiences and expectations as consumers of the MCH Program services. They also attend US conferences depending upon availability of funds.

Training and education of the MCH staff are carried out at three levels: Individual on-site consultation provided twice a year for the Coordinators in the four states on developing policy and procedures, program implementation, data collection, data analysis and interpretation, and improving data capacity; The FSM Annual MCH Workshop held each year bringing together the MCH Coordinators, the MCH Data Clerks, the CSHCN Coordinators, hospital and public health administrators, physicians, nurses, and stakeholders from the National Government and State Health Depts where issues are discussed related to improving services and state data capacity and early intervention services for CSHCN; and Special conferences and other educational opportunities provided to staff who attended in-person or on-line courses from the Fiji School of Medicine, PACRIM Conference in Honolulu, Pacific Basin Medical Association Conferences, and American Pacific Nurses Leadership Conference.

The FSM is composed of four different societies with 13 different major languages. English, however, is the official language of the governments and is taught in the schools. The MCH Program takes serious consideration for the need of a workforce that is competent and culturally sensitive in providing services including awareness, education and counseling and materials development.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

FSM's MCH Program historically has a solid working collaboration with the public and private sectors as well as governmental and non-governmental organizations. MCH programs and other HRSA programs, programs within Public Health, governmental agencies, and local public and private organizations were involved throughout the NA and planning process, as were a wide array of stakeholders and family members. The MCH Program has been instrumental in forging strong partnerships to enhance disease prevention and public awareness activities. Much of the work accomplished by MCH staff is done in collaboration with other state agency staff, particularly Public Health and Education. MCH personnel work with other state agency staff on a nearly daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements.

The MCH Program and Family Planning Programs are well-integrated. Efforts to address unintended pregnancy, preconception health and preventing risky teen sexual behavior are both family planning and MCH objectives. MCH funds are not used for direct family planning services, but rather to support population-based activities around unintended pregnancy prevention.

MCH is also well integrated with Immunization Program, the Substance Abuse and Mental Health Program and the HIV/STD Prevention Program. Again, the efforts and objectives are shared between programs and has allowed for expand staff coverage and program implementation.

Relationships with the Non-Communicable Disease Bureau are strong and support work between MCH projects and programs such as Diabetes, Cancer, Tobacco Control and other chronic disease prevention and health promotion. For example, the NCD Bureau has long worked with MCH to promote healthy weight among children.

The FSM Dept of Education, in particular the Early Intervention Service, is an essential partner of the CSHCN Program. Together the agencies offer services for children served by the FSM Dept of Education and the Public Health CSHCN Program.

In the four states, an interagency agreement for the CSHCN Program has been developed that involves the CSHCN Program, MCH Program, the State Hospital, the Dept of Education, Special Education Program, the Early Childhood Education Program, and the Parent Network. This interagency agreement has been established to assure that children are screened for disabilities, and those who are suspected of having a disability are referred to the CSHCN Program for an assessment. The agreement also assures that an interdisciplinary team of members from each of the agencies is available

to conduct an assessment, develop the individualized plan, and provide or coordinate the services.

The MCH Program works with the Kosrae, Chuuk, Pohnpei and Wa'ab (on Yap) Community Health Centers to improve accessibility and expand primary care services for low-income and vulnerable populations. These efforts include information and data sharing; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

The MCH Program has an established working partnership with the College of Micronesia for training needs of both clinical and programmatic staff, conducting awareness activities in nutrition and physical activity, and to prevent and control non-communicable disease.

Each state has established coordinated relationships and linkages among the local Depts of Education - Special Education, Population Education Projects, and Early Childhood Education Program; Depts of Agriculture- Family Food Production and Nutrition Program; Nutrition Council, in the case of Pohnpei; and social services. With the establishment of these inter agency linkages, gaps in communication have narrowed and duplication of efforts has been minimized.

The MCH Program works with international agencies such as Red Cross, World Health Organization and United Nations Children's Fund and Population Fund.

The MCH Program staff at the state level work closely with parents support groups, church leaders, women's groups, and community and traditional leaders. However, the current use of the parent/consumer partnership is limited. Outside the CSHCN population, the parent/consumer partnership is non-existent at this time. The MCH program intends to expand its parent/consumer partnership in the coming years to improve public input into the program and its policies and objectives.

The FSM does not have the following programs or services: Title V- Maternal, Infant, and Early Childhood Home Visiting Grants, Title XIX - Medicaid, Title XXI - Child Health Insurance Program, Social Services, Child Welfare Programs, Social Security Administration, WIC Program, or Rehabilitation Services.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Feedback received in response to the needs assessment was helpful in identifying issues impacting MCH populations in the FSM that stakeholders consider a priority. In keeping with the guiding principles of the process, the focus was on the goal of identifying select areas for MCH investment, so that a comprehensive set of interventions could be employed at more depth to affect five-year outcomes. In addition, the chosen priorities needed to be tied to the MCH scope of influence in order to assure ultimate impact. In order to do so, each potential priority was connected to a national or population-based outcome measure. To this end, a justification was prepared for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period. Survey findings were grouped by each of the six domains. Presented below is a summary of the highest priority issues identified by the respondents by FSM State and overall for each domain.

Table 13 Top Priorities by Domain for Each State and FSM Overall

	Chuuk	Kosrae	Pohnpei	Yap	FSM
Women's/ Maternal	Access to health services (63.3% 19/30)	Access to health services (62.5% 20/32)	Access to and use of contraception (63.6% 28/44)	Access to and use of contraception (63.6% 21/33)	Access to health services (57.6% 80/139)
Perinatal/ Infant	Infant mortality (60.0% 18/30)	Infant mortality (46.9% 15/32)	Infant mortality; Education and support for breastfeeding (TIE 40.9% 18/44)	Infant mortality (42.4% 14/33)	Infant mortality (47.5% 66/139)
Child	Obesity (70.0% 21/30)	Understand and prevent injury and death due to accidents or	Obesity; Nutrition/food security (TIE 52.3%	Nutrition/food security (66.7% 22/33)	Obesity (55.4% 77/139)

		other preventable events; Screening for developmental issues/delays (TIE 56.3% 18/32)	23/44)			
Adolescent	Adverse childhood events/toxic stress/trauma including generational trauma/ violence and safety (60.0% 18/30)	Supports for young adults to help them become more independent and achieve goals such as higher education, employment and independent living (53.1% 17/32)	Adverse childhood events/toxic stress/trauma including generational trauma/ violence and safety (47.7% 21/44)	Adverse childhood events/toxic stress/trauma including generational trauma/ violence and safety (66.7% 22/33)	Adverse childhood events/toxic stress/trauma including generational trauma/ violence and safety (50.4% 70/139)	
CSHCN	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful (65.5% 19/29)	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful (62.5% 20/32)	Training for parents/ caregivers on coordinating care for child (70.5% 31/44)	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful (60.6% 20/33)	Training for parent/ caregivers on coordinating care for child (62.8% 86/137)	
Cross-Cutting/ Systems Building	Screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues (59.3% 16/27)	Screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues (46.9% 15/32)	Better and clearer communication about healthy behaviors, health services and supports in your area (61.4% 27/44)	Better and clearer communication about healthy behaviors, health services and supports in your area (54.5% 18/33)	Better and clearer communication about healthy behaviors, health services and supports in your area (51.5% 70/136)	

Presented below is a summary of the three highest priority issues identified by the respondents by FSM overall for each domain. Respondents were allowed to choose three answers and therefore response percent and response count will not add up to 100% or total respondents, respectively.

Table 14 Top Three Priorities by Domain

Domain	Priorities
Women's/ Maternal	Access to health services (57.6% 80/139)
	Access to and use of contraception (56.8% 79/139)
	Home visiting/community health resources to help manage and improve health (42.8% 67/139)
Perinatal/ Infant	Infant mortality (47.5% 66/139)
	Education and services to help prevent and care for premature babies (38.1% 53/139)
	Education and support to help with breastfeeding (34.5% 48/139)
Child	Obesity (55.4% 77/139)
	Nutrition/food security (53.2% 74/139)
	Trying to understand and prevent injury and death due to accidents or other preventable events (40.3% 56/139)
Adolescent	Adverse childhood events/toxic stress/trauma including generational trauma/ violence and safety (50.4% 70/139)
	Supports for young adults to help them become more independent and achieve goals such as higher educational/ training, employment and independent living (40.3% 56/139)
	Involving families in programs, services and community supports geared towards teenagers/young adults (37.4% 52/139)
CSHCN	Training for parent/ caregivers on coordinating care for child (62.8% 86/137)
	Support individuals, families and communities to make changes that will make it more likely for youth to be healthy and successful (56.9% 78/137)
	Non-medical transition to adulthood (43.1% 59/137)
Cross- Cutting/ Systems Building	Better and clearer communication about healthy behaviors, health services and supports in your area (51.5% 70/136)
	Screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues (50.7% 69/136)
	Health disparities (35.3% 48/136)

Several themes arose from the findings, including access to direct health services, prevention, access to social and support services and improved communication. Access to direct health services is seen in the well-woman, prenatal care and well-adolescent visits. Prevention is apparent in prevention of obesity through physical activity and nutrition, prevention of infant mortality through adequate prenatal care, and prevention of poor outcomes through behavioral health screening and support. Social and support services are important to support transition to healthy adulthood, physical activity, and navigation of coordinated care systems. Another key finding was stakeholders identified the community as critical in impacting the health status of MCH populations and viewed better and clearer communication about healthy behaviors, health services and community resources as a priority.

The FSM selected the final seven priorities based on the needs assessment finding.

- Access to health services- Improve women's health through cervical cancer and anemia screening
- Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening
- Improve child health through healthy weight through physical activity and nutrition promotion
- Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)
- Provide care coordination training for parents/caregivers of Children with Special Health Care Needs

Improve health promotion communication

Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits

The comparison to prior priorities identified in 2015 is slightly different given the broader view FSM MCH program took of the priorities to improve overall health through specific actions. Three domain priorities (women, perinatal, adolescent) were continued, three domain priorities (child, CSHCN, cross-cutting) were replaced given past performance and needs assessment findings, a systems building domain priority was added.

Table 15 Comparison of Previous and Current Priorities

Previous Priority- 2015	Current Priority- 2020	Notes
	Women/Maternal	
Improve women's health through cervical cancer and anemia screening	Access to health services- Improve women's health through cervical cancer and anemia screening	Continued
	Perinatal/Infant	
Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding	Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	Continued with slight alteration to wording and removal of breastfeeding
	Child	
Improve child health through providing vaccinations and screening for developmental delays	Improve child health through healthy weight through physical activity and nutrition promotion	Replaced
Reduce childhood injury		
	Adolescent	
Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior and poor outcomes	Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)	Continued although added assessment of violence and safety
	CSHCN	
Provide a transitional services for youth identified as having Special Health Care Needs	Provide care coordination training for parents/caregivers of CSHCN	Replaced
Improve identification of CSHCN through screening for developmental delays		
	Cross-Cutting/ Systems Building	
Improve oral health of children		Removed
Reduce tobacco use in pregnant women		Removed
	Improve health promotion communication	New priority
	Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits	New priority

The FSM selected the following five National Performance Measures and two State Performance Measures in relation to the identified priority areas.

Table 16 Priority Linkage to Performance Measure

Priority	Performance Measure
Women/Maternal	
Access to health services- Improve women's health through cervical cancer and anemia screening	#1 Well-woman visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Perinatal/Infant	
Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	#3 Risk-appropriate perinatal care: Percent of pregnant women who receive prenatal care beginning in the first trimester
Child	
Improve child health through healthy weight through physical activity and nutrition promotion	#8 Physical Activity: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Adolescent	
Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior and poor outcomes	#10 Adolescent well-visit: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
CSHCN	
Provide care coordination training for parents/caregivers of CSHCN	#11 Medical home: Percent of CSHCN, ages 0 through 17, who have a medical home
Cross-Cutting	
Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits	A state performance measure will be developed.
Systems Building	
Improve health promotion communication	A state performance measure will be developed.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$587,235	$404,139	$579,204	$517,478
State Funds	$467,000	$440,000	$440,000	$440,000
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$1,054,235	$844,139	$1,019,204	$957,478
Other Federal Funds	$637,000	$637,000	$637,000	$444,470
Total	$1,691,235	$1,481,139	$1,656,204	$1,401,948

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$569,064	$519,806	$517,478	
State Funds	$440,000	$440,000	$440,000	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$1,009,064	$959,806	$957,478	
Other Federal Funds	$598,000	$585,000	$653,300	
Total	$1,607,064	$1,544,806	$1,610,778	

	2022	
	Budgeted	Expended
Federal Allocation	$519,806	
State Funds	$115,000	
Local Funds	$816,225	
Other Funds	$0	
Program Funds	$0	
SubTotal	$1,451,031	
Other Federal Funds	$653,300	
Total	$2,104,331	

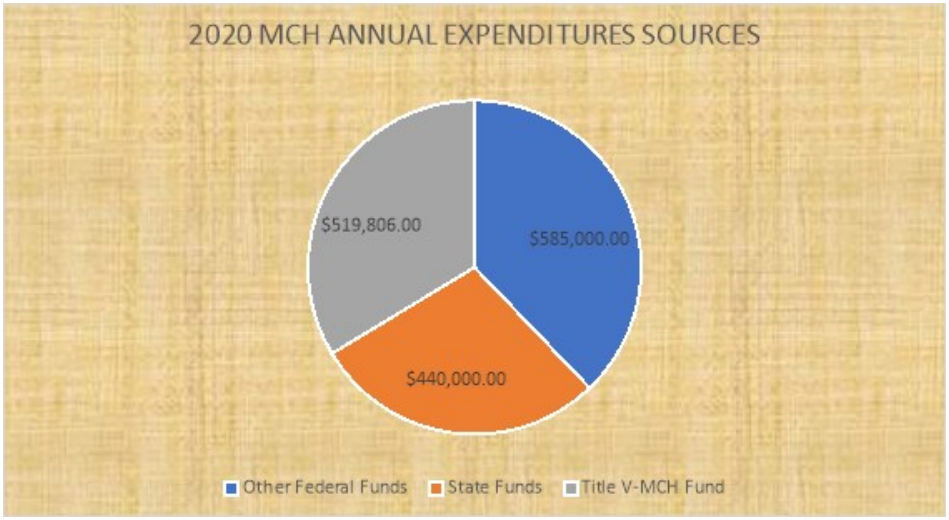
III.D.1. Expenditures

Expenditures:

Overview of Expenditures

The mission of the Federated States of Micronesia (FSM) Maternal and Child Health (MCH) Program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs (CSHCN), adolescents, and our families through the delivery of quality prevention programs and effective partnerships. The FSM MCH Program works towards achieving this overarching work through the Divisions of Primary and Preventive Care under the Department of Health and Social Services in each of the four (4) FSM States and with our internal and external partnerships. During Fiscal Year 2020, from 10/01/2019 through 09/30/2021 the FSM MCH Program reported to have a total collaborative funds in the amount of $1,544,806. Of the total, $519,806 was provided by the Title V MCH Program.

The chart below shows the collaborative funds available to the FSM MCH Program for use during fiscal year 2020.



The FSM Department of Health and Social Affairs, Division of Health, Family Health Services Unit, manages the following programs:

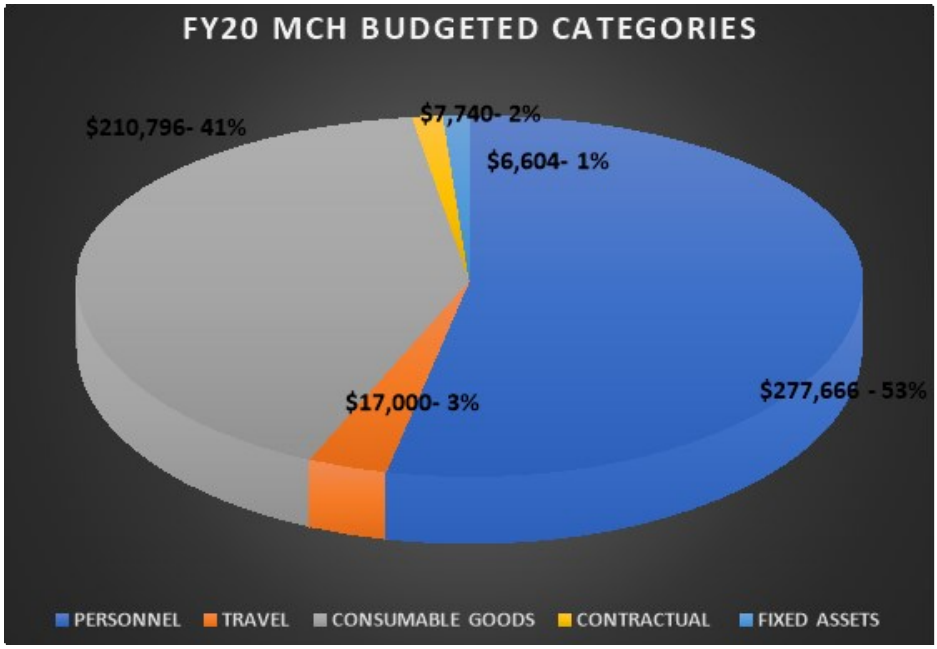
Title V Maternal & Child Health Program
Title X Family Planning Program
Early Hearing Detection and Intervention (EHDI) Program
State Systems Development Initiative Project

USE OF THE TITLE V FUNDS

The chart, below, shows the 2020 Title V MCH Budget as prepared to also include FSM States' activities to response to the current and emerging needs resulting from the Covid-19 pandemic. The emerging needs, mostly are evolved around the FSM States' Health Departments prevention and containment efforts of the Novel Coronavirus.

Use of Federal Title V Funds

1. MCH Budget for FY 2020.



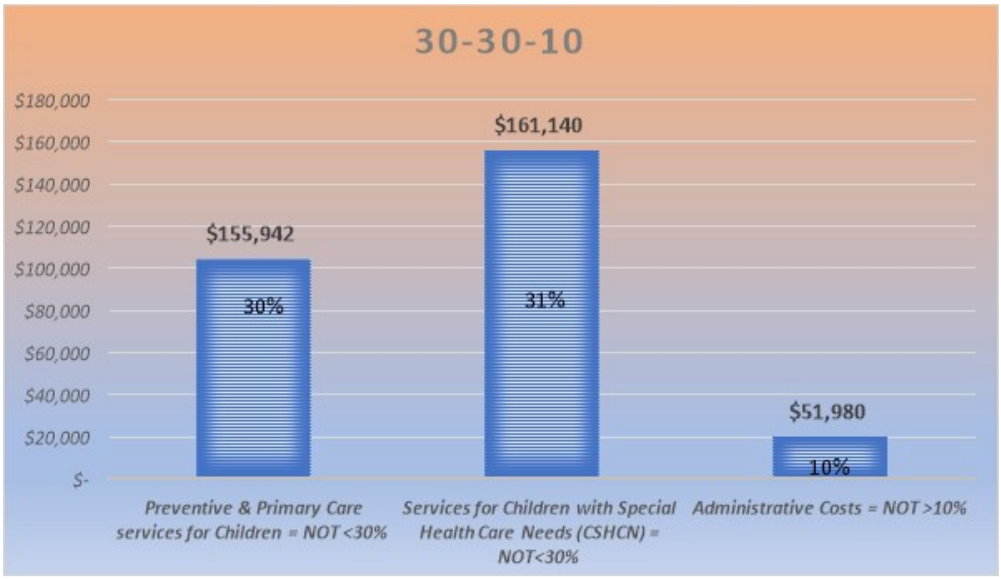
The budget was developed in order for the MCH Program to also respond to and support FSM States' prevention and containment efforts of the Covid-19 pandemic as well as to support the States' decentralization efforts of Essential Services for the Public Health Preventive Programs, including the Maternal and Child Health (MCH) Program. The decentralization of Essential Services initiative includes relocating or shifting of essential public health services from the main/central public health clinics to the dispensaries and Community Health Centers around the main islands in the four FSM States.

Legislative Requirements Met

The FSM MCH Program is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. The Family Health Financial Management Specialist provides the Family Health Services (FHS) Unit Program Manager a monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage status report. In collaboration with the FHS Unit Program Manager and programmatic staff, the FHS Unit Financial Management Specialist develops the Title V Block Grant Budget and continuously monitor and track expenditures to ensure compliance with the legislative financial requirements. Expenses are monitored and tracked through the National and State's accounting system called the, FUNDWARE. The Title V legislation requires a minimum of 30% of the block grant funds to be utilized for preventive and primary care for children and a minimum of 30% of the block grant funds for services for CSHCN. In addition, no more than 10% of the grant may be used for administration costs.

Based on expenditure report provided by the FSM Investment Division showed that FSM MCH Program spent $155,942 or 30% on Preventive and Primary care for children, $161,140 or 31% on Children with Special Health Care Needs, and $51,980 or 10% on Administrative Costs. This shows that FSM MCH Program has met the required legislative percentages of 30-30-10 for FY 2020.

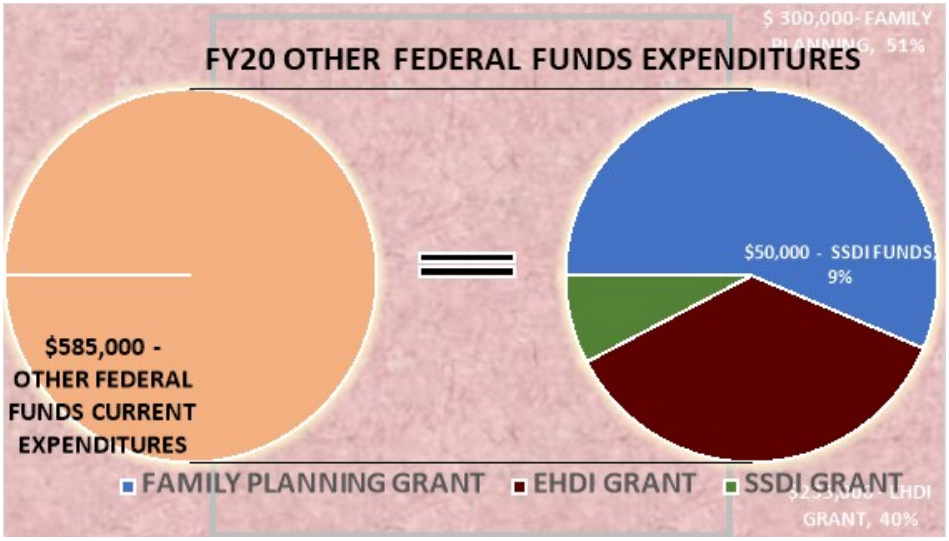
The chart below provides an overview of the required federal allocation for the FY 20. expenditures.



Other Federal Funds

The chart below provides an overview of the Other Federal Funds expended that were also under the direction of the FSM Department of Health and Social Affairs, Family Health Services (FHS) Unit Program Manager, which are also listed in Form 2 [State Systems Development Initiative (SSDI), Early Hearing Detection and Intervention (EHDI) and Title X Family Planning]. The Other Federal Funds total expenditure for 2020 was $585,000.

As stated, the Other Federal Funds listed herein above were administered under the FSM Department of Health and Social Affairs, FHS Unit. Therefore, the Unit continues to align its goals and objectives that serve the MCH population to maximize and leverage resources across all programs. This strategy is in line with the FSM Division of Health Services, FHS Unit's



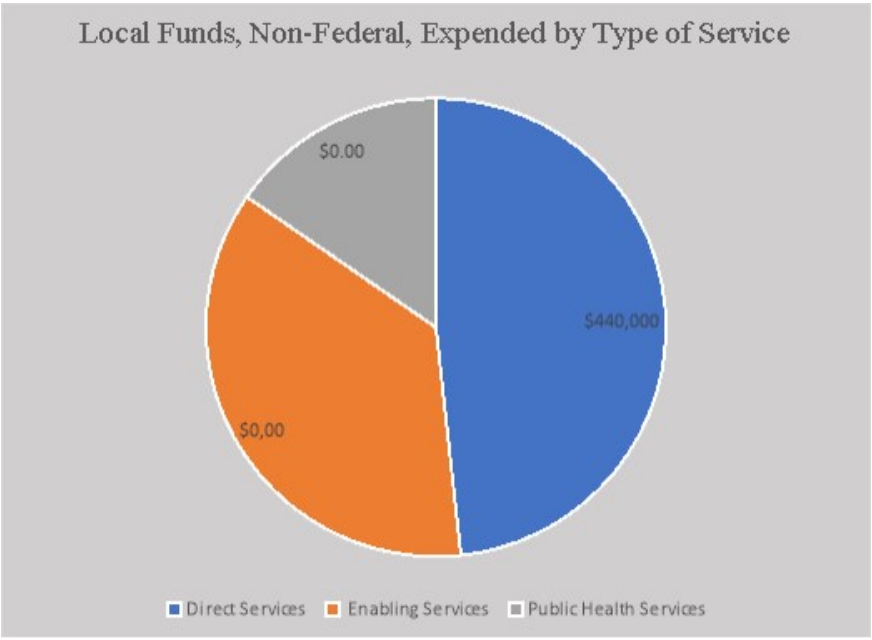
efforts for utilizing the life course framework in implementing programs and interventions to address the health and wellness needs and outcomes for the FSM MCH populations.

Total State Match

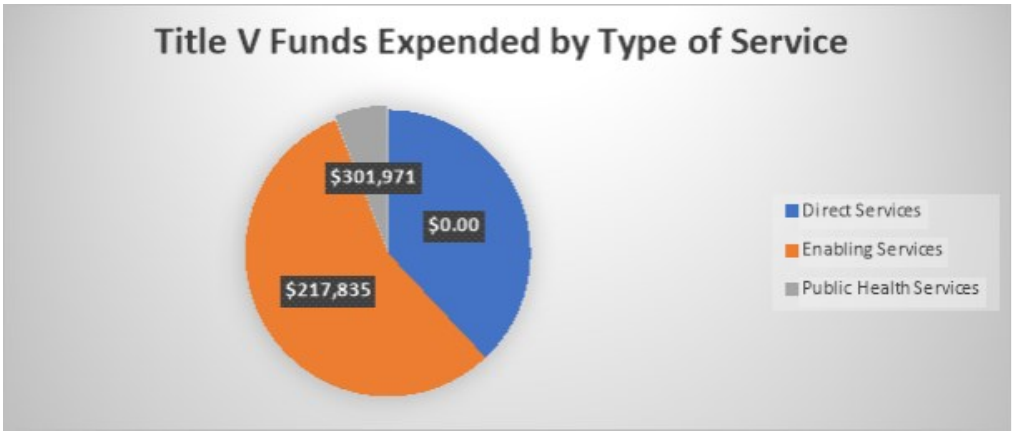
The total State Matching Funds in the amount of $440,000 is the required match requirement, which includes a $3 match in non-federal funds for every $4 of federal MCH Block Grant Funds expended, which is also the Maintenance of Effort for FSM as established in 1989. Included in the total state match was personnel salaries for staff at the

National Department of Health and Social Affairs and staff at the FSM States Department of Health and Social Services, that provides direct services to the MCH population. Since the Funds contribute to direct services, majority of the Title V funds contributes to enabling services and public health services and systems. The actual total amount of in-kind support provided by the States to the maternal and child health population in 2020, was much greater than the $440,000 reported as established in 1989. However, and since we cannot increase the State Match amount, the Title V MCH program will only report budgeted salary percentages that were stated on the proposed non-federal budget.

The chart below shows how the $440,000 of State Matching Non-Federal funds were expended by type of service as defined by the Title V guidance: direct, enabling and public health services and systems.

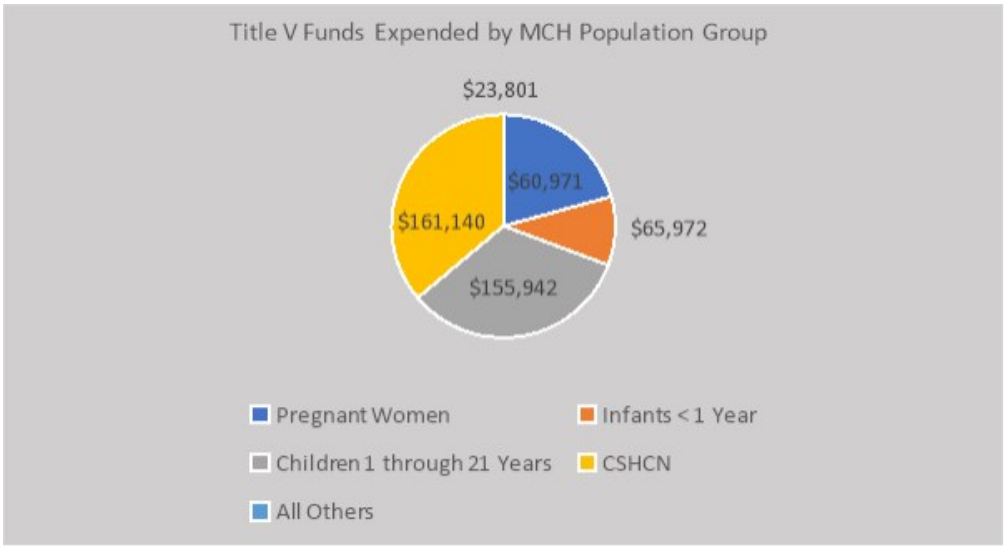


The chart below shows how the $519,806 of Title V MCH funds were expended by type of service as defined by the Title V guidance: direct, enabling and public health services and systems.

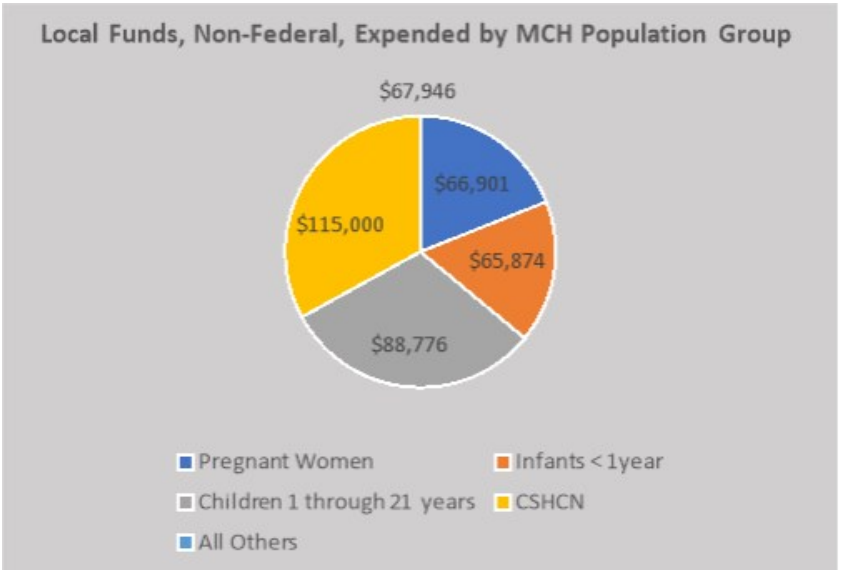


Expenditures by Population Group

The chart below shows how the $519,806 of Title V MCH funds were expended to serve the Title V population groups: Pregnant Women and Mothers, Infants <1year old, Children 1-21years old; Children with Special Health Care Needs,



The chart below shows how the $440,000 of local funds, non-federal, were expended to serve the Title V population groups: Pregnant Women and Mothers, Infants <1year old, Children 1-21years old; Children with Special Health Care Needs, All Others.



III.D.2. Budget

Budget

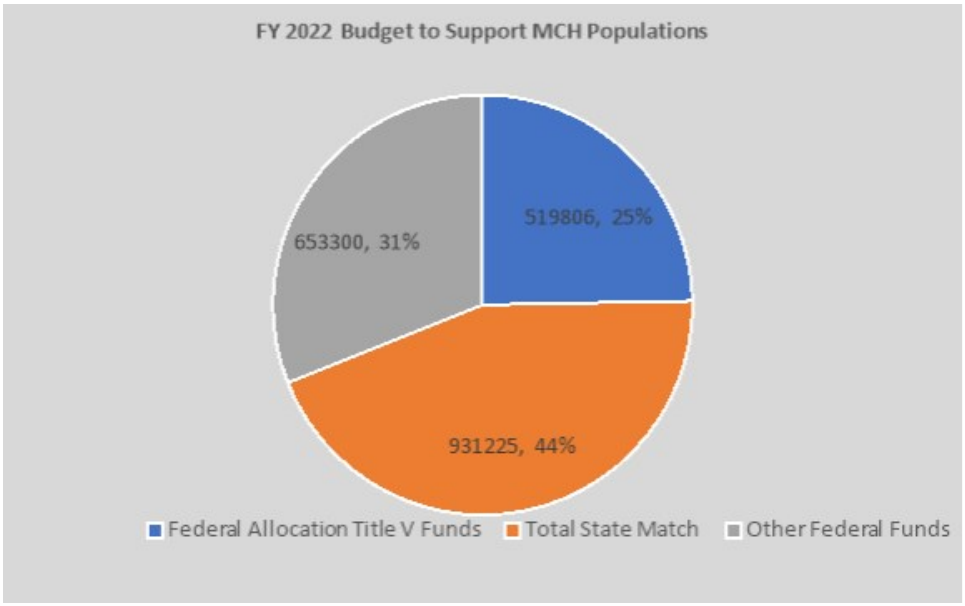
Budget Overview

The mission of the FSM Maternal and Child Health (MCH) Program is to promote and improve the health and wellness of women, infants, children, including children with special health care needs, adolescents, and their families through the delivery of quality prevention programs and effective partnerships. The MCH Program works towards achieving this overarching work through the Divisions of Preventive and Primary Health Care under each of the four (4) FSM States' Department of Health and Social Services and with their internal and external partnerships. In Fiscal Year 2022 FSM is estimating a total state MCH budget of $2,104,331.

The MCH Program's 2022 State Action Plan was developed based on feedback provided in the 2020 MCH Block Grant Review Summary Statement. Acting on the recommendations made the FSM MCH Program requested for a Technical Assistance (TA) Training to address the recommendations made for the challenges cited in the 2021 Grant Application. A Technical Assistance (TA) Training was authorized for FSM and a Virtual TA Training was conducted on May 18, 20, 25 and 26, 2021. The TA Sessions were two hours long, each, and attended by the National and State MCH Program Coordinators and key staff. Therefore, the MCH Program's State Action Plan determines where the MCH federal grant dollars are budgeted.

The MCH grant, all Other Federal Funds under the Family Health Services Unit, and the Total State Match continues to align its overarching goals and objectives to effectively leverage resources to serve the MCH population. To ensure that the financial reporting forms are correctly filled out and that the use of Title V MCH dollars are consistent with the intent of the Title V law, FSM requested for a Technical Assistance (TA) Training with the MCH Bureau. The Maternal and Child Health Bureau (MCHB) convened a Technical Assistance (TA) site visit on Friday, January 31, 2020 on Pohnpei, Federated States of Micronesia (FSM). Cassie Lauver, ACSW, Public Health Consultant, was the lead for the TA event on site. The Technical Assistance provided to the FSM was focused on our reporting of the Budget/Expenditures consistent with the federal Title V Legislation and the Maternal and Child Health Block Grant Application/Annual Report guidance. In follow up to that on-site TA event, additional TA was provided to the FSM via Zoom February 15 to February 24, 2021. In addition to the FSM National Government being represented in the follow-up TA, Maternal and Child Health (MCH) staff from Pohnpei, Kosrae, Chuuk and Yap States also participated.

The Title V funds consist of personnel salaries and fringe benefits that support the following staffing: FSM National MCH Program Coordinator/Program Manager for the Family Health Services Unit, Family Health Services Unit System and Data Manager, FSM States' MCH Program Coordinators, Heath Assistants, Health Educators, Outreach Workers, Dental Assistants, Laboratory Assistants, and State MCH Financial Specialists. The following staff works not only for the MCH Program but works across all programs under the Family Health Services Unit. In addition to personnel salaries and fringe benefits, the Title V funds are budgeted towards Professional Services, Public Education and All Other Costs to support the MCH Programs activities and initiatives stated on the State Action Plan. Professional services costs will include continuous development of a MCH Web-based database system, specialty services in Pediatric Cardiology, and other related trainings and technical assistance. Public education and awareness costs include print, radio, local newspapers, and social media posts on the importance of preventive screenings, pre-conception health, prenatal care, screening and treating anemia in women. Community awareness includes publicizing available services and programs, oral health care, breast feeding and early booking education. The MCH Program will continue to educate the community on the importance of developmental screenings, healthy weight and physical activity and nutrition. Title V funds are utilized towards supporting the breastfeeding support groups, adolescent after school initiatives, Women's Health Month, and all other community outreach events that serve the MCH population. FSM is currently not doing newborn bloodspots and metabolic screenings. Funds are also utilized towards other costs such as travel, fuel, freight, membership dues and fees, communication costs, space rental, car rental, boat rental, Department's highspeed internet line, satellite dishes, etc. The chart below provides an overview of the FSM MCH Program's FY 2022 Budget as reported on Form 2.

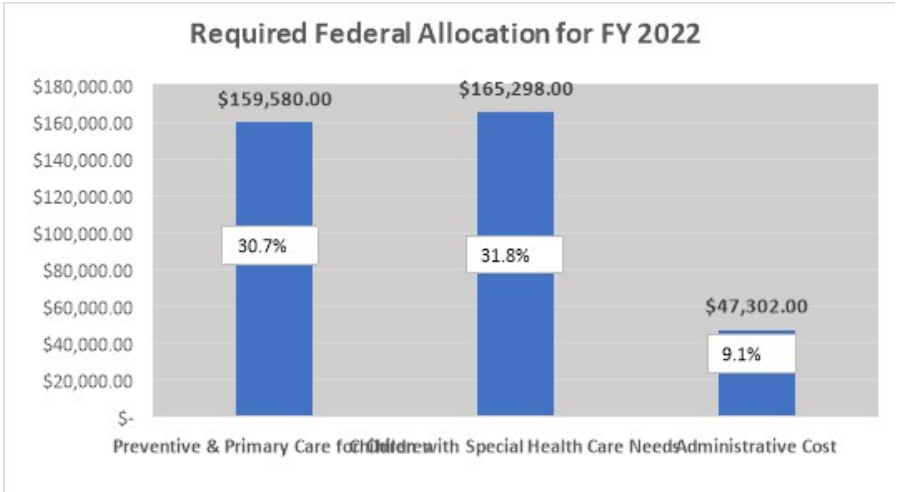


Legislative Requirements Met:

The FSM MCH Program is continuously striving to ensure that the program is complying with the legislative financial requirements for the Title V Block Grant. As stated, the Family Health Services Unit Financial Management Specialist is supported by the Title X Family Planning Program. Because the Family Planning Program is one of the programs within the Family Health Services Unit, the Financial Management Specialist is able to work across programs. One of the major duties and responsibilities of this Financial Specialist is to continuously ensure that MCH funds are being budgeted and expended per the minimum required 30-30-10 percentage. The FHS Unit Financial Management Specialist provides the FHS Unit Program Manager a monthly fund status report that consist of current funds available, funds encumbered, funds expended and the legislative required 30-30-10 percentage.

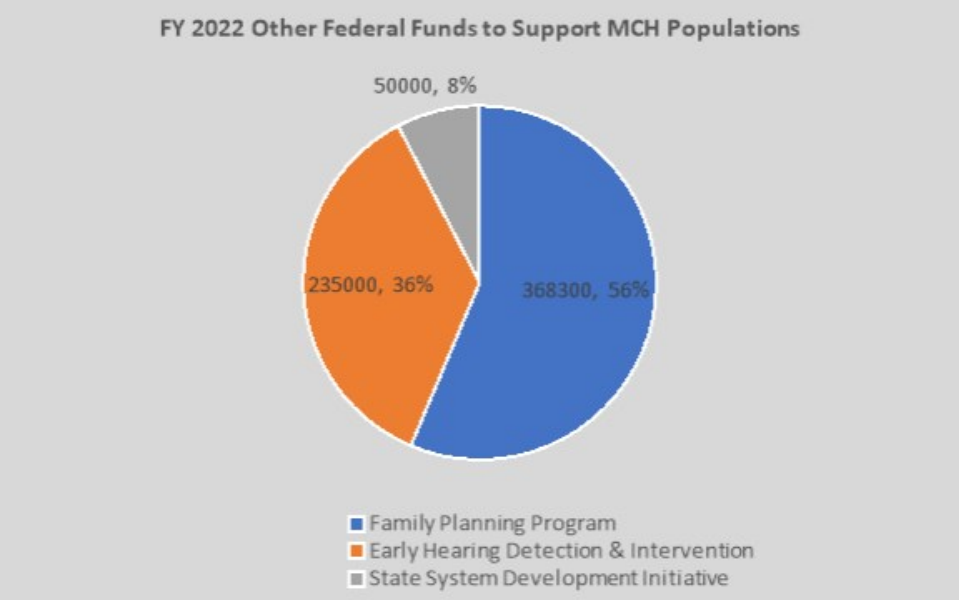
The Fiscal Year 2022 Title V Block Grant budget proposal of $519,806 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age is budgeted at $88,367 which is at 17% of the total federal award. Preventive and Primary Care for Children is budgeted at $159,580 which is at 30.7 % of the total federal award. Children with Special Health Care Needs is budgeted at $165,298 which is 31.8% of the total federal award. Administrative cost is budgeted at $47,302 which is 9.1% of the total direct costs of the federal grant award.

A total of $59,259 is budgeted for All Other Costs such as travel, dues and subscriptions, repairs and maintenance, communication services, meeting venue rental, car and boat rental and freight. The chart below provides a budget overview of the required federal allocation for the FY 22 Budget.



Other Federal Funds

The chart below provides an overview of the Other Federal Funds budgeted that are under the direct authority of the FHS Unit Program Manager which are also listed in Form 2 [Early Hearing Detection and Intervention (EHDI) Grant Funds, State Systems Development Initiative (SSDI) Grant Funds, and Title X Family Planning Grant Funds]. As indicated in Form 2 of this report, the total amount included under the "Other Federal Funds" category is $653,300.



Total State Match

The FSM is in a unique situation where our matching requirement relative to the actual amount of Federal MCH dollars we receive is less than the MOE level in 1989. As an outcome of the Financial TA Training, held in-county from February 15-24, 2021, FSM redefined and recalculated the state match and came up with a new MOE level of $931,225 higher than the level reported in 1989. There was considerable discussion about what qualifies as a match both in terms of dollars spent as well as in-kind contribution. Many examples were given of what could qualify as match. These included the FSM purchase of drugs for Rheumatic Heart Disease, rent and supplies contributed by States to assure the effective operation of clinics for the MCH population, funding from other sources that contribute to salaries of individuals that staff maternal and Child health clinics, etc. However, by law FSM cannot change the MOE as established in 1989. Other federal funds cannot be used to match the Federal MCH Block Grant as well as non-federal funds that are matching other programs cannot be used to also match this program. The MCH match is budgeted at $931,225 which is comprised of the FSM National and States Health Departments in-kind funds that is consistent with the new MOE calculation and as required by the FY1989 Maintenance of Effort requirements. Therefore, the Federal-State Title V Block Grant Partnership subtotal is $2,104,331. The Total State Match funds are budgeted towards the purchase of drugs for Rheumatic Heart Disease, rent and supplies contributed by States to assure the effective operation of clinics for the MCH population, and personnel salaries and fringe benefits for staff at the four FSM State Departments of Health and Social Services that provides direct services to the MCH population. Since the State Match funds contribute to direct services, majority of the Title V funds contribute to enabling services and public health services and systems.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Federated States of Micronesia

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

III.E.2.a. State Title V Program Purpose and Design

The mission of the FSM Department of Health and Social Affairs is to promote and improve the health and wellness of women, infants, children including children with Special Health Care Needs, adolescents, and their families through the delivery of quality preventive programs and effective partnerships in an island setting or island communities in the FSM.

Along with that purpose, the MCH Program envisions an island community where all women, infants and children, including children with special health care needs, adolescents and their families are healthy and thriving. The FSM MCH Program is the main Public Health program within the Family Health Services Unit that works with or partners with the other public health and social programs to implement promotional and preventive activities for the women and children population. Each state program implements its own program at the state level while the FSM National program guides, directs, and monitors their performance to ensure transparency, compliance, and accountability of the activities. Title V funds are administered through the Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs. The FSM National MCH workforce is housed at the National Level of the Health Department, within the Family Health Services Unit while the State MCH Workforce is housed within the Division of Preventive and Primary Health care in each of the FSM States Department of Health and Social Services. The Family Health Services Unit within the Division of Health Services was formed in 2007 to address the needs of the FSM MCH population, comply with the varying program requirements of the MCH Title V Block Grant, and link all opportunities between MCH programs to work through challenges common across programs since the separation of the Division of Education from the then FSM Department of Health, Education and Social Affairs. Strategies identified within the FSM MCH Title V State Action Plan are designed to: 1) reduce barriers and increase access to comprehensive preventive, screening, and treatment services; 2) provide health promotion to reduce the incidence of preventable diseases, morbidities, and mortalities; and 3) improve coordination across programs that serve MCH populations. While a good number of the staff is funded by sources other than Title V, all contribute to the Title V mission and MCH priorities.

The following are brief biographies of senior level national and state management and key staff involved in the Title V needs assessment and application processes.

Program Manager, Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs: Mr. Dionisio E. Saimon holds a Bachelor of Science Degree in Political Science from the State University of New York, College at Brockport. Aside from his experience in the MCH Program, Mr. Saimon has experience working with the Department of Education and local governments in Pohnpei State, FSM. Mr. Saimon has been involved in numerous Needs Assessment Activities for both the Title X Family Planning Program and Title V MCH Program in the FSM. Mr. Saimon continues to provide guidance and input to all programs within the Family Health Services Unit at both the national and state levels The Program Manager position is funded at 1.0 FTE through Title V Block Grant funds.

System and Data Manager, Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs: Ms. Arlynn Linny holds a Master of Arts Degree in Theology from the International Theological Seminary in Los Angeles, California. Aside from her experience in the MCH Program, she has over 10 years of experience working with the FSM Behavioral Health Program where she has conducted numerous populations surveys, such as the Mental Health Survey, Substance Abuse Survey and the BRFSS Survey throughout the four states in the FSM. Ms. Arlynn Linny manages FSM-HER, a web-based data collection and reporting system for the FSM EHDI Program. She also developed an EPI Info registry for the Title X Family Planning and Title V MCH Program. In her capacity as data manager, Ms. Arlynn Linny provides epidemiological support to the Title V MCH Program and assists in reviewing and making recommendations for data collection, quality improvement, and data analysis.

Title X Family Planning Program Coordinator: Mr. Stanley S. Mickey holds a Diploma from Seventh Day Adventist High School in Pohnpei, Federated States of Micronesia. Aside from his experience in the MCH Program, Mr. Mickey has experience working in the Community Health Centers, managing and coordinating youth organizations as Youth Council President and Implementing Faith Based Organization activities as an Advisor. Mr. Mickey has been involved in numerous Needs Assessment Activities for both the Title X Family Planning Program and Title V MCH Program in the FSM.

Financial Management Specialist, Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs: Ms. Vicky Nimea graduated from Park College, in Kansas City, Missouri with a Bachelor of Arts Degree in Business Administration in 1993. In addition to overseeing program

budgeting and monitoring expenditures, Ms. Nimea participates in program monitoring and outreach activities provided by the Title X Family Planning and MCH Title V Programs. She also provides assistance with community awareness and educational materials that are used to inform the community regarding important initiatives or projects.

MCH Program Coordinator, State of Chuuk: Ms. Pipiana Wichep is a Nurse by profession graduated from the Nursing School in Majuro, Republic of the Marshall Island. Aside from MCH work, Ms. Wichep does administrative and clinical work. Miss Wichep is a certified HIV/AIDS/STD Counselor, Reproductive Health Trainers/health educators, and a certified Visual Inspection with Acetic Acid (VIA) Trainer.

MCH Program Coordinator, State of Pohnpei: Ms. Marcy Lorrin is a Nurse by profession graduated from the Nursing School in Saipan, Northern Mariana Islands. Aside from MCH work, Ms. Lorrin does clinical work and awareness activities in both MCH and Family Planning programs. Ms. Lorrin is certified in IUD insertion and removal and VIA and Pap smear screening and treatment. She is a RH trainer on services and awareness to program staff and assisting staff in the other programs and dispensaries.

MCH Program Coordinator, State of Kosrae: Ms. Patricia Tilfas is a Nurse by profession graduated from the Nursing School in Majuro, Republic of the Marshall Islands. Aside from MCH work, she is actively involved with the women groups, faith-based groups and other community-based organizations. She works with these NGOs providing screening services and awareness activities. She develops good working relationships with the women groups in the communities to assist with the breastfeeding campaign and youth groups initiative to preventing teen pregnancy and STI's. Ms. Tilfas also works with the faith-based organizations to raised awareness on important matters relating to mothers and adolescents. She also participated in the Kosrae youth summer camps and retreats and participated in all community events such as the liberation day event and sports events.

MCH Program Coordinator, State of Yap: Ms. Janet Fichwemang is a Nurse by profession graduated from the Nursing School in Majuro, Republic of the Marshall Islands. Prior to becoming the MCH Program Coordinator for Yap State, Ms. Fichwemang was the CSHCN/EHDI Programs Coordinator for Yap State. Ms. Fichwemang has extensive experience working with parents, especially parents of children with special health care needs, community-based organizations and faith-based organizations. Ms. Fichwemang was one of the key staff involved in conducting the Yap-Specific and FSM- Wide Needs Assessment activities.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

III.E.2.b.i. MCH Workforce Development

Assessing the Workforce Capacity of the FSM MCH Program, **In 2021, there are 23 full-time** staff in the four FSM States funded by the Title V Program. Out of the total 23 employees, nine are in Chuuk state; three in Kosrae state; four in Pohnpei state; and seven in Yap state. Of the nine MCH staff in Chuuk state, three are staff nurses, two coordinators, two health assistants, one health educator, and one dental assistant. Out of the total three employees in Kosrae state there is one coordinator, one staff nurse, and one dental nurse. Of the total four staff in Pohnpei state, there is one coordinator, one dental nurse, one staff nurse, and one lab technician. Of the total seven staff in Yap state, there are two coordinators, two staff nurses, two dental nurses and one dental technician. In addition, there are four data specialists funded by the SSDI Program that play integral role in the Title V Program, who work in each State's Vital Statistics and Record Division. These staff constitute the MCH Programs in each of the State Public Health Depts and they directly provide all of the preventive and primary health care services at no cost to clients.

The four MCH Coordinators, at state level, are responsible for assuring that clinical services are provided to pregnant women, infants, children, and CSHCN. All four MCH Coordinators are Registered Nurses. In addition, each of the States provides in its own budget a medical doctor for the MCH Program. Together they are responsible for assuring that clinical services are provided.

At the National level, one MCH Program Coordinator staff is paid by the MCH program. The National Family Planning Program Coordinator, data manager and financial specialist, although paid for by a different program, also assist the National MCH Program Coordinator in the planning, developing, implementing, and monitoring of MCH program services and activities at the national and state levels on a daily basis. These staff constitute the core staff at the national level and the National MCH Program Coordinator reports directly to the Secretary of H&SA.

The following are brief biographies of senior level national and state management and key staff involved in the Title V needs assessment and application processes.

Program Manager, Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs: Mr. Dionisio E. Saimon holds a Bachelor of Science Degree in Political Science from the State University of New York, College at Brockport. Aside from his experience in the MCH Program, Mr. Saimon has experience working with the Department of Education and local governments in Pohnpei State, FSM. Mr. Saimon has been involved in numerous Needs Assessment Activities for both the Title X Family Planning Program and Title V MCH Program in the FSM. Mr. Saimon continues to provide guidance and input to all programs within the Family Health Services Unit at both the national and state levels The Program Manager position is funded at 1.0 FTE through Title V Block Grant funds.

System and Data Manager, Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs: Ms. Arlynn Linny holds a Master of Arts Degree in Theology from the International Theological Seminary in Los Angeles, California. Aside from her experience in the MCH Program, she has over 10 years of experience working with the FSM Behavioral Health Program where she has conducted numerous populations surveys, such as the Mental Health Survey, Substance Abuse Survey and the BRFSS Survey throughout the four states in the FSM. Ms. Arlynn Linny manages FSM-HER, a web-based data collection and reporting system for the FSM EHDI Program. She also developed an EPI Info registry for the Title X Family Planning and Title V MCH Program. In her capacity as data manager, Ms. Arlynn Linny provides epidemiological support to the Title V MCH Program and assists in reviewing and making recommendations for data collection, quality improvement, and data analysis.

Title X Family Planning Program Coordinator: Mr. Stanley S. Mickey holds a Diploma from Seventh Day Adventist High School in Pohnpei, Federated States of Micronesia. Aside from his experience in the MCH Program, Mr. Mickey has experience working in the Community Health Centers, managing and coordinating youth organizations as Youth Council President and Implementing Faith Based Organization activities as an Advisor. Mr. Mickey has been involved in numerous Needs Assessment Activities for both the Title X Family Planning Program and Title V MCH Program in the FSM.

Financial Management Specialist, Family Health Services Unit, Division of Health Services, FSM

Department of Health and Social Affairs: Ms. Vicky Nimea graduated from Park College, in Kansas City, Missouri with a Bachelor of Arts Degree in Business Administration in 1993. In addition to overseeing program budgeting and monitoring expenditures, Ms. Nimea participates in program monitoring and outreach activities provided by the Title X Family Planning and MCH Title V Programs. She also provides assistance with community awareness and educational materials that are used to inform the community regarding important initiatives or projects.

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MCH Program Coordinator, State of Kosrae: Ms. Patricia Tilfas is a Nurse by profession graduated from the Nursing School in Majuro, Republic of the Marshall Islands. Aside from MCH work, she is actively involved with the women groups, faith-based groups and other community-based organizations. She works with these NGOs providing screening services and awareness activities. She develops good working relationships with the women groups in the communities to assist with the breastfeeding campaign and youth groups initiative to preventing teen pregnancy and STI's. Ms. Tilfas also works with the faith-based organizations to raised awareness on important matters relating to mothers and adolescents. She also participated in the Kosrae youth summer camps and retreats and participated in all community events such as the liberation day event and sports events.

MCH Program Coordinator, State of Yap: Ms. Janet Fichwemang is a Nurse by profession graduated from the Nursing School in Majuro, Republic of the Marshall Islands. Prior to becoming the MCH Program Coordinator for Yap State, Ms. Fichwemang was the CSHCN/EHDI Programs Coordinator for Yap State. Ms. Fichwemang has extensive experience working with parents, especially parents of children with special health care needs, community-based organizations and faith-based organizations. Ms. Fichwemang was one of the key staff involved in conducting the Yap-Specific and FSM- Wide Needs Assessment activities.

The FSM MCH Program invites parents of CSHCNs to workshops and conferences in the FSM where they present their experiences and expectations as consumers of the MCH Program services. They also attend US conferences depending upon availability of funds.

Training and education of the MCH staff are carried out at three levels: Individual on-site consultation provided twice a year for the Coordinators in the four states on developing policy and procedures, program implementation, data collection, data analysis and interpretation, and improving data capacity; The FSM Annual MCH Workshop held each year bringing together the MCH Coordinators, the MCH Data Clerks, the CSHCN Coordinators, hospital and public health administrators, physicians, nurses, and stakeholders from the National Government and State Health Depts where issues are discussed related to improving services and state data capacity and early intervention services for CSHCN; and Special conferences and other educational opportunities provided to staff who attended in-person or on-line courses from the Fiji School of Medicine, PACRIM Conference in Honolulu, Pacific Basin Medical Association Conferences, and American Pacific Nurses Leadership Conference.

The FSM is composed of four different societies with 13 different major languages. English, however, is the official language of the governments and is taught in the schools. The MCH Program takes serious consideration for the need of a workforce that is competent and culturally sensitive in providing services including awareness, education and counseling and materials development.

III.E.2.b.ii. Family Partnership

Family Partnership

The FSM Family Health Services (FHS) Unit has focused efforts to meet the demands of the transition of our department's structure from one of independent vertical programming into Units, setting the structure to merge all programs and services for the MCH population into one Unit, meeting grant requirements and maintaining services to our target groups. The MCH Program not only partners with internal programs such as the Family Planning and Newborn Hearing Screening Programs, 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. In order to ensure that services are effectively meeting the needs of the local population, programs under the FHS Unit have taken a collective approach towards involving families in programmatic decision making. The MCH Program has, over the years, supported learning collaborative involving Parent Advisory Council members to focus on training and capacity building among families as a means for strengthening meaningful family engagement. Parent Advisory Councils have been established and in operation in the four (4) FSM States for over a decade now. Strategic and program planning, congruent with the integration of programs and services for the Unit, continues to involve small-group discussions, individual surveys, partnership meetings, and social media. Focus groups with various target groups continue to be conducted. The Title V MCH program partnered with the Title X Family Planning program to facilitate focus groups with adolescents from high schools throughout the FSM on adolescent needs assessments. The focus groups were conducted with the intent to ensure that strategic and program planning are guided by family/consumer input. Surveys were also conducted throughout the communities and health facilities throughout the four FSM States. Families were also invited to participate in the development and review of the State Action Plan and the Executive Summary, as part of the Block Grant Development and Review. Moreover, for materials development, programs seek input from families who actively participate in MCH programs on items such as program brochures. Program informational materials, including those specific for the adolescent population, are reviewed by the Information and Education (I & E) committee in each State and approved by them prior to printing and distribution to the community as a mechanism for ensuring that print materials are culturally and linguistically appropriate. The I & E committees are made up of community members of varying ethnic backgrounds, age groups, and locality, representative of each State population. MCH related advisory committees with family partners as members include the: State Interagency Advisory Council (SIAC), Presidential National Advisory Coordination Council (PNACC) on Disabilities, Newborn Hearing Screening Parent's Leadership Council and CSHCN interdisciplinary re-evaluation Teams. Families and community members also take active roles in the planning and coordinating of annual FSM wide events, such as with the International Women's Day and Women's Health Month.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

III.E.2.b.iii.a. MCH Epidemiology Workforce

The purpose of the Federated States of Micronesia-State Systems Development Initiative Grant is to develop, enhance, and expand FSM's Title V Maternal and Child Health (MCH) data capacity efforts in the workforce arena for mothers, children, adolescents and children with special health care needs.

Additionally, the SSDI Project has been actively involved in leading efforts around the FSM's comprehensive MCH Needs Assessment. As part of the Needs Assessment Steering Committee, which is composed of the Family Health Section (FHS) Unit System and Data Manager, National Family Planning Program Coordinator, State MCH Program Coordinators and MCH Data Clerks, the FHS Unit Program Manager is also the SSDI Project Coordinator, takes part in identifying goals, framework, and methodology that will be used to complete the MCH Needs Assessment every year.

In the summer of 2020, the FSM MCH system and data manager attended and completed the training course in MCH epidemiology that was hosted by Citymatch. Due to Covid-19 pandemic, there were limited MCH activities including data work that the State MCH staff at the national and state level normally do in their respective States.

All along, it's been known that the FSM MCH program lacks the capability in the epidemiolocal field for mothers and children. Epidemiology training needs to evolve to provide capacity and skills to respond to the needs of women and children as well as dynamic and complex public health emergencies. This will strengthen the MCH epidemiology workforce, as well as the health systems they function within and the state, national, regional and global emergencies they respond to. Continuous professional development activities must also be available to support the current workforce adapt, as well as expand new and suitable skilled staff for the challenges ahead.

Epidemiology has a central role in public health practice, education and research, and is generally what FSM lacks in the MCH programs. It is inevitable among the health leaders in the FSM that the nation needs to have local epidemiologists in epidemiological capacity within the health workforce and health research. The FSM government needs sufficient high-level epidemiological trainings provided to interested locals who will be essential to building this capacity in the health and educational arena.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Federated States of Micronesia (FSM) Maternal and Child Health (MCH) Systems Development and Improvement Project continues to focus grant resources to improve data capacity for the FSM Title V MCH Block Grant program. The SSDI Project continues to be greatly involved with the FSM Title V MCH program by working towards improving the health information system infrastructure at the national and four state hospitals to standardize and formalize the design, recording, reporting and analysis of data at each State's hospital on inpatient, outpatient, pharmacy and related services. In addition, the SSDI project supplements the MCH program data capacity with modifications and updates to existing FSM Title V MCH data repository system to include the National Outcomes Measures (NOMs), National Performance Measures (NPMs), Evidence/Informed Strategies Measures (ESMs) and State Performance Measures (SPMs). The SSDI project worked closely with the MCH program during the 5year needs assessment process for developing and completing the FSM's 2020 MCH Needs Assessment for the next 5 years.

The Work Plan for the FSM SSDI Program has two goals, five Objectives and twelve Action Steps. The action steps and activities will enable FSM SSDI project to meet the targets which will ultimately lead FSM toward achieving the 2 goals. Goal 1: Build and expand FSM MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation; and Goal 2: Provide partnership and on-site support for the development and implementation of a data collection tool/process that will enable tracking of Title V MCH Block Grant NPM data.

The SSDI program in the four FSM States continues to collect and provide data for the FSM national health department relating to MCH and SSDI programs activities and also provide data for other reporting requirements by the national and state governments. The Four (4) Data Clerks are hired as program key staff and posted at the four FSM State hospitals' record rooms, vital statistics division, to collect data to support inform MCH program activities/services. MCH Data clerks will collect information on MCH population domains (Women, Children, etc) from hospital records and analyze and update all data prior to submission to national office. The data clerks will continue to collect data, review and submit all MCH and other mandatory data indicators and measures for the MCH and SSDI programs. In addition, the four state MCH programs will also collect data for the Minimum/Core Datasets, NPM, SPM & ESMs through a standardized data collection tool that can generate and report fully on the selected measures.

Ongoing collaboration and data collection and sharing agreements with all collaborative partners, State and National reporting sources such as State public hospitals, National and State Special Education programs, and advisory groups and includes regional and national partners, i.e. state MCH Programs and HRSA and to verify validity of information reported for quality monitoring purposes. Given the continued budget cut in SSDI funds in recent years, compounded by further setbacks in launching a web-based database system, the need to get a fully functional MCH database system in place is now critical and delaying the FSM-MCH progress since data management and analyses for improved reporting, is affected. Despite the lack of a fully operational Web-MCH module at the moment, the FSM States have continued to collect data on MCH Services and have shown significant improvements in their data collection process. Hopefully, there will be funding available in the future to enhance population-based surveys or research that can help the FSM MCH program report on data that is representative of the whole population of the FSM on MCH issues.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Recognizing that the MCH Action Plan involves other public health programs, agencies and other groups, FSM MCH program is collaborating with these affiliates to strengthen the work they have been doing for the mothers, children, children with special health care needs and adolescents. Sharing and reporting of data within the group loop is very useful and helpful, especially for the MCH programs.

The MCH and STI programs along with other Public Health Programs and partners reviewed the current MCH data collection and reporting instruments for the Women & Children Health populations and discussed possible edits or updates that are needed on the reporting tools. The review process was essential for follow-up purposes and also to validate the data reported on the NPM, SPM and ESM. Updating the tools and instruments for data collection is necessary to ensure that accurate information is collected by the MCH Program for decision making. Discussions on the tools and instruments for the CSHCN population is still inadequate for MCH measures.

The FSM SSDI program continues to work with the FSM-HER database system developer (Scheier Consulting, Inc.) to create and establish MCH module to collect and report data for pregnant women, infant, children, and children with special health care needs. The web-based system is in the developmental stage and should be able to collect and store MCH data for decision making and reporting purposes.

The data system capacity that is in place has help shape the overall data system of the MCH program at the national and state level. Information and data that FSM MCH program is collecting and reporting results from below sources:

- Prenatal, antenatal, post-natal data
- Newborn early hearing screening data
- National Vital Statistics
- State Hospital Medical Records
- State Dental Clinics
- State Dept. of Education
- Special Education
- Early Childhood Education Program
- MiCare Health Insurance
- Department of Public Safety

III.E.2.b.iv. MCH Emergency Planning and Preparedness

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The COVID-19 pandemic has been another reminder of the importance of communication skills in connecting with the public during a public health emergency and the essential role of effective communication in the successful implementation of control measures. There was a collective work by several FSM entities which resulted in the Strategic Plan on Emergency Medical Services for Children. The plan was developed to guide the development of the programs that work with the FSM children within four years period up to 2022.

The National Disaster Response Plan was established in 2016 for the FSM which is called “Federated States of Micronesia National Disaster Response Plan 2016”. This plan provides for the establishment of national institutional arrangements for the Federated States of Micronesia (FSM) government for responding to emergency and disaster events within the country. It includes arrangements for preparedness, monitoring for potential events and response at the national level to manage national level events and support state level events. It also outlines arrangements to guide state disaster response plans and their connection to the national level arrangements. It includes provisions for accessing international support.

FSM has been the recipient of two cooperative agreements: Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP). The main functions of these cooperative agreements are preparedness and response planning.

When Zika virus was reported in the state of Kosrae, one of four states within the Federated States of Micronesia (FSM), the territory responded with a PHEP-funded mosquito control and elimination campaign. Campaign activities included an island-wide mosquito survey, communication efforts such as travel advisory brochures, radio programs, and posters, and mosquito spraying at the homes of all reported cases.

Since the healthcare system in the FSM can only provide limited emergency care and services for adults including the mothers; however, much work still needs to be done to be able to have the policies, infrastructure, and staff to provide for the emergency medical needs of children. The focus of the analysis on the plan was to improve the health outcomes of children who require emergency medical care in the FSM. The mission for FSM children is- to save children’s lives, reduce suffering, and limit disability by providing quality pediatric emergency medical services in the FSM. The strategic priorities are Program management, Human resources, Financial support and Program capacity.

Program management goal is to establish emergency management system for pre-hospital services in all FSM States. For Human resources, all pediatric emergency medical care services personnel will meet FSM established licensing and certification requirements. Emergency and pediatric medical emergency care services will be incorporated into FSM’s annual budget in all FSM states as well as the national level. Last but not least, basic pediatric medical emergency care services, equipment and supplies will be available in all government healthcare facilities for hospital and pre-hospital responses. Finally, there is a need to address the identified training gaps in leadership, communication and social skills, as well as emergency response.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

III.E.2.b.v.a. Public and Private Partnerships

The Health Care Delivery system in the Federated States of Micronesia (FSM) involves a collaborative effort between the MCH Program and other Federal Programs providing preventive care services to serve the MCH population domains. The State leadership has established policies and passed State laws to waive costs of health care for all MCH population domains. The overall goal for this collaborated effort is to ensure delivery of quality health care and needed services for the MCH population.

The FSM has one national Department of Health services which is headed by a Secretary and four (4) State Departments of Health services that are overseers by the Directors. The national and state governments work jointly to provide reliable, accessible and quality services to its citizens. The national government provides coordination while the delivery of services within each state is the primary responsibility of the state governments. By mutual agreement between the states and the national government, administration, monitoring and reporting of federal programs such as the Maternal and Child Health rests with the national government.

The state health care delivery system is divided into clinical and preventative health and is managed by a Director. The day-to-day management and operation of the MCH Program rests with the MCH Coordinator who is supervised by the chief of public health. In the provision of direct services to the women of child-bearing age population, the other public health staff nurses, state hospital physicians and nursing staff assist the coordinator.

This organization and structure provided a unique opportunity for integrated services between clinical and public health services. However, in such a financially constrained environment - systematic, evidence based, and outcome driven change is challenging. The MCH Title V Program is administered by the FSM Department of Health and Social Affairs, Division of Health Services, within the Family Health Services Unit. Preventive and primary care services for women and children are provided at the Division of Preventive and Primary Care Women's Clinic, Children's Clinic – both are located at the State Division of Public Health Services. MCH services include prenatal care, postpartum care, women's health, education and counseling, case management of high risk pregnancies, family planning, HIV/STI Prevention, and preventive screenings such as Pap smear, blood pressure screening, diabetes screening with blood sugar testing, well-child visits, developmental screenings for infants and children, newborn screening, and oral health services. Since its inception, the Family Health Services Unit, and primarily the MCH Program, has worked diligently with the State Hospitals' outpatient clinics and its medical providers on applying evidence-based approaches towards improving healthcare and health outcomes within the population. In addition to working closely with Hospital and public health clinic providers, the MCH program works closely with community-based partners on a variety of projects.
A significant role that MCH plays towards ensuring access to healthcare is by working towards reducing barriers to access. The inability to pay or lack of insurance is often cited as a major obstacle in seeking preventive healthcare. For the FSM, federally funded programs' commodities and services are provided at no cost to the client. FSM has a Health Insurance Program known as "Mi-Care" Insurance Program. Mi-Care is optional for private businesses and State Government employees however it is mandatory enrollment of all National Government employees. In the 2018 FSM BRFSS, it shows that among the 2,712 survey respondents, 71.3% of respondents said they did not have health-care coverage.

The Department of Health Services (DHS) in each of the four (4) States is responsible for running curative, preventive and public health services, including the main hospital, peripheral health centers, and primary health care centers. There is a main public hospital in each of the four states. The health care system in FSM is provided by both public and private health care facilities. The facilities provide wide range of health care services from outpatient services to certain surgical procedures. However, there are some specific tests and procedures that these facilities cannot perform due to lack of medical specialists, specific diagnostic procedures and various types of complicated health care services and medical equipment, which cause patients to be referred off-island. The Title V MCH Program funds provided the critically needed funding that makes a major difference for families in the FSM. The MCH and other federally funded programs are at the "core" or the main pillars to provide needed preventive services for families in the FSM.

Part of the Healthcare delivery system for the people of the FSM is through partnership with affiliated entities like the

US military programs. According to the Pacific Basin Tele-health Resource Center, a bill submitted by Hawaii Senator Schatz: April 30, 2019 - A new bill aims to use telemedicine to help some of the nation's most remote veterans access healthcare: The Compacts of Free Association Veterans Review Act, introduced by Sens. Brian Schatz (D-HI) and Lisa Murkowski (R-AK), would create a three-year pilot program to improve access to care for veterans living in Palau, the Marshall Islands and the Federated States of Micronesia. The three countries are covered by a treaty called the Compact of Free Association with the United States, which enables residents of those nations to work and live in countries under the US jurisdiction. While residents of US territories like Guam and the Commonwealth of the Northern Marianas Islands receive full health benefits from the Department of Veteran Affairs after serving in the military, veterans living in other Pacific island nations do not have that benefit.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

FSM is not eligible for US Medicare and Medicaid Programs. It is also significant that in the FSM, there are no cash-supplemented welfare programs except the FSM Social Security Benefit program. Therefore, services provided by the MCH programs are free to the public.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

State Action Plan Introduction

The FSM MCH Program identified priorities under the MCH population domains were well-defined in the 2020 Five years need assessment document. Strategies and interventions were employed in the initial plan to reach and affect the five-year outcomes. At the beginning of the new grant cycle, Covid-19 pandemic had emerged and most of the planned activities were either halted or not fully implemented. At the end of the first year, the stated significance for each of the NPMs, ESMs and SPMs were thoroughly reviewed, and found to have limited and inadequate information for the FSM MCH programs to continue reporting on. In addition to the inadequacy of the of information stated, the program was provided with numerous recommendations for improvement to FSM's 2022 Action Plan based on findings made and reported in the 2020 MCH Block Grant Review Summary Statement. In this manner, the state MCH programs thoroughly reviewed all types of sources that are available within and around their programs to enhance the MCH program activities. The priorities including the developed SPM measures and strategies that were identified for next year will continue to be the focus activities of the state MCH programs.

Realizing the vigorous nature of MCH as well as the depth and breadth of issues specific to these domain populations, FSM MCH will continue to systematically assess needs during the remaining four-year time frame. It is being discussed among the FSM MCH programs that the programs determined to address the performance measures on specific indicators that could measure success within the next four-year period. A thorough review of the State action plan shows that the selected SPMs aligns and amplifies our FSM MCH priorities. Every MCH programs in the FSM will measure and report progress against the priorities and state performance measures in a clear and transparent way. This state action plan provides a framework for how FSM MCH program will implement the important work in 2022 and beyond.

There are four selected SPMs that the MCH programs deems best and achievable at the programs level from next year forward. The NPM for the Child domain remains the same. Following are the new changes in the State Action Plan that the FSM MCH programs will be implementing in 2022.

Priority	2021 National Performance Measure	2022 State Performance Measure
Women/Maternal		
Access to health services- Improve women's health through cervical cancer and anemia screening	NPM#1 Well-woman visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	SPM1-Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening. SPM2- Percent of women (15-44 years old) screen for anemia for the past year
Perinatal/Infant		
Improve perinatal/infant outcomes through early	NPM#3 Risk-appropriate perinatal care: Percent of	SPM3- Percent of pregnant women who are

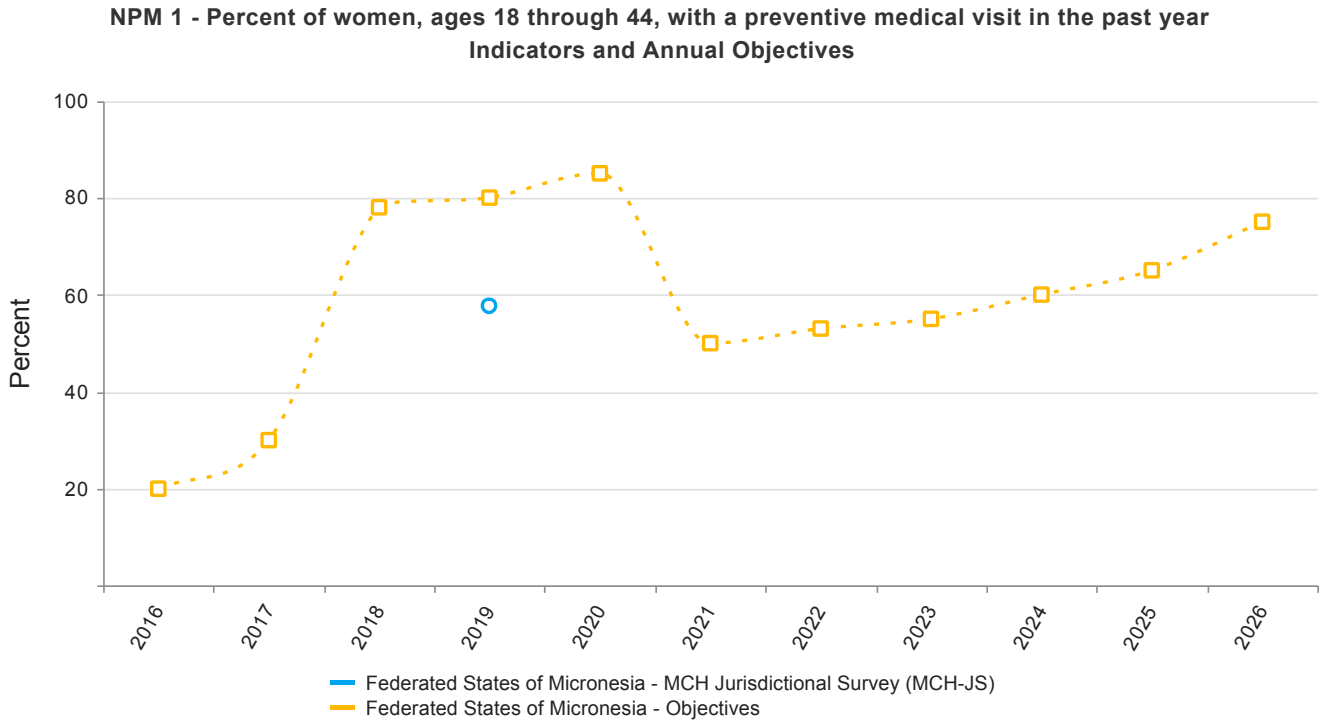
and adequate prenatal care services including Gestational Diabetes and anemia screening	pregnant women who receive prenatal care beginning in the first trimester	screened for gestational diabetes by 24-28weeks.
Child		
Improve child health through healthy weight through physical activity and nutrition promotion	NPM#8 Physical Activity: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	NPM#8 Physical Activity: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Adolescent		
Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)	NPM#10 Adolescent well-visit: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year	SPM4- Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools
Children with Special Health Care Needs		
Provide care coordination training for parents/caregivers of Children with Special Health Care Needs	NPM#11 Medical home: Percent of children with special health care needs, ages 0 through 17, who have a medical home	SPM5- Percent of parents/caregiver receiving training on specialty care for children with special health care needs (CSHCN)

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2017	88.0	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	MCH-JS-2019	11.0 %	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	MCH-JS-2019	23.1 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2019	24.5	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2019	15.9	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	13.2	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	MCH-JS	Data Not Available or Not Reportable	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		85
Annual Indicator	57.8	57.8
Numerator	9,102	9,102
Denominator	15,758	15,758
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	20	30	78	80	85
Annual Indicator	26	76.3	73.8	57.8	43.9
Numerator	1,320	9,582	7,074	9,102	3,046
Denominator	5,080	12,556	9,589	15,758	6,940
Data Source	MCH program	MCH program	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	53.0	55.0	60.0	65.0	75.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of women, ages 18 through 44, attending community outreach events on preventive medical visits in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective						

State Performance Measures

SPM 1 - Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	7.0	12.0	15.0	20.0	30.0

SPM 2 - Percent of women (15-44 years old) screened for anemia for the past year

Measure Status:				Active	
State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		13	75	22	27
Annual Indicator	15.1	69.5	19.4	14.6	10.8
Numerator	615	5,272	4,384	384	2,526
Denominator	4,064	7,584	22,610	2,629	23,492
Data Source	MCH program	MCH program	MCH program and Census	MCH program	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	50.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Women/Maternal Health - Entry 1	
Priority Need	
Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits.	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By 2022, increase the percentage of women ages 18 through 44 who had a preventive visit by 4%.	
Strategies	
Conduct community-based education focusing on women's health to promote annual preventive visits	
ESMs	Status
ESM 1.1 - Percent of women, ages 18 through 44, attending community outreach events on preventive medical visits in the past year	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Federated States of Micronesia) - Women/Maternal Health - Entry 2

Priority Need

Access to health services- Improve women's health through cervical cancer and anemia screening

SPM

SPM 1 - Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.

Objectives

By 2022, increase the percentage of women ages 21-65 years who received a Pap or VIA screenings by 4%.

Strategies

Utilize community-based education in partnership with other agencies focused on women's health to promote annual preventive visits

State Action Plan Table (Federated States of Micronesia) - Women/Maternal Health - Entry 3

Priority Need

Access to health services- Improve women’s health through cervical cancer and anemia screening

SPM

SPM 2 - Percent of women (15-44 years old) screened for anemia for the past year

Objectives

By 2022, increase anemia screening in childbearing age women (15-44 years old) by 4%.

Strategies

Increase access and visibility to services through community outreach on preventive visits

Women/Maternal Health Plan – FY 2022

The priority for this domain is to improve women and maternal health through cervical cancer and anemia screening. The National performance measure that was being selected in the initial year was percentage of women with a past preventive medical visit, which was non-achievable in the FSM due to incapability of the MCH program to track and collect data for the NPM. There are two SPM from the previous grant cycle that FSM MCH programs will continue to implement in 2022. Due to insufficient data and information on the NPMs under the women/maternal domain, the FSM MCH programs have selected two SPMs to address the priority that falls under the women/maternal area. List the SPM

Since cervical cancer is one of the leading causes of death in the women population in the FSM. The FSM MCH program wishes to prioritize cervical screening by increasing Pap smear and VIA screening during a women's preventive visit so cervical cancer can be detected early and treated. The FSM MCH Program noticed an increase in women being diagnosed with anemia during pregnancy. In an effort to increase a woman's health status prior to pregnancy the program instituted screening of all women for anemia not just pregnant women.

The preventive strategic measure that FSM would like to implement next year under the women domain is the environmental strategies on information disseminations and educational awareness during annual events in the communities. The MCH programs will improve women/maternal health through continued collaboration with other public health programs on promoting women's health through annual preventive visits to the hospitals or clinics that provide preventive screenings in the women population group.

It was being discussed and stated in the action plan that the state MCH programs will implement the strategy in reaching out to the communities on preventive cervical cancer screening in 2022, and that at least have 4% of the women population ages (21-65 yrs. old) completing their Pap/VIA screening. Also, by the end of the year, anemia screening in women of childbearing ages (15-44 years) will reach 4% of the respective targeted population.

2022 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerator/ Denominator**
Women/Maternal Health				
Access to health services- Improve women's health through cervical cancer and anemia screening	Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.	By 2022, increase the percentage of women ages 21-65 years who received a Pap or VIA screenings by 4%.	Utilize community-based education in partnership with other agencies focused on women's health to promote annual preventive visits	Number of women ages 21-65 years old who had Pap or VIA screening in the past year Total number of women ages 21-65 years old in the State
	Percent of women (15-44 years old) screen for anemia for the past year	By 2022, increase anemia screening in childbearing age women (15-44 years old) by 4%.	Increase access and visibility to services through community outreach on preventive visits	Total number of women (15-44 years old)

Women/Maternal Health Plan – FY 2022

The priority for this domain is to improve women and maternal health through cervical cancer and anemia screening. The National performance measure that was being selected in the initial year was percentage of women with a past preventive medical visit, which was non-achievable in the FSM due to incapability of the MCH program to track and collect data for the NPM. There are two SPM from the previous grant cycle that FSM MCH programs will continue to implement in 2022. Due to insufficient data and information on the NPMs under the women/maternal domain, the FSM MCH programs have selected two SPMs to address the priority that falls under the women/maternal area. List the SPM

Since cervical cancer is one of the leading causes of death in the women population in the FSM. The FSM MCH program wishes to prioritize cervical screening by increasing Pap smear and VIA screening during a women's preventive visit so cervical cancer can be detected early and treated. The FSM MCH Program noticed an increase in women being diagnosed with anemia during pregnancy. In an effort to increase a woman's health status prior to pregnancy the program instituted screening of all women for anemia not just pregnant women.

The preventive strategic measure that FSM would like to implement next year under the women domain is the environmental strategies on information disseminations and educational awareness during annual events in the communities. The MCH programs will improve women/maternal health through continued collaboration with other public health programs on promoting women's health through annual preventive visits to the hospitals or clinics that provide preventive screenings in the women population group.

It was being discussed and stated in the action plan that the state MCH programs will implement the strategy in reaching out to the communities on preventive cervical cancer screening in 2022, and that at least have 4% of the women population ages (21-65 yrs. old) completing their Pap/VIA screening. Also, by the end of the year, anemia screening in women of childbearing ages (15-44 years) will reach 4% of the respective targeted population.

2022 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerator/ Denominator**
Women/Maternal Health				
Access to health services- Improve women's health through cervical cancer and anemia screening	Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.	By 2022, increase the percentage of women ages 21-65 years who received a Pap or VIA screenings by 4%.	Utilize community-based education in partnership with other agencies focused on women's health to promote annual preventive visits	Number of women ages 21-65 years old who had Pap or VIA screening in the past year Total number of women ages 21-65 years old in the State
	Percent of women (15-44 years old) screen for anemia for the past year	By 2022, increase anemia screening in childbearing age women (15-44 years old) by 4%.	Increase access and visibility to services through community outreach on preventive visits	Total number of women (15-44 years old)

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2019	24.5	NPM 3 NPM 4
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2019	15.9	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 3
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4

National Performance Measures

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Indicators and Annual Objectives

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0.3
Numerator	0	5
Denominator	100	1,833
Data Source	N/A	Vital Statistics
Data Source Year	N/A	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.2	0.2	0.1	0.0	0.0	0.0

Evidence-Based or –Informed Strategy Measures

ESM 3.1 - Percent of low birth weight infants born in the hospital

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	1.0	0.7	0.5	0.2	0.0

State Performance Measures

SPM 3 - Percent of pregnant women who are screened for gestational diabetes by 24-28weeks.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	30.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Perinatal/Infant Health - Entry 1	
NPM	
NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	
Objectives	
By the end of 2022, increase the rate of pregnant women receiving prenatal services beginning in the 1st trimester of pregnancy by 35%.	
Strategies	
To conduct community awareness workshops and events on the importance of early pregnancy booking.	
ESMs	Status
ESM 3.1 - Percent of low birth weight infants born in the hospital	Active
NOMs	
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.2 - Neonatal mortality rate per 1,000 live births	
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	

State Action Plan Table (Federated States of Micronesia) - Perinatal/Infant Health - Entry 2

Priority Need

Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening

SPM

SPM 3 - Percent of pregnant women who are screened for gestational diabetes by 24-28weeks.

Objectives

By 2022, increase the rate of pregnant women receiving prenatal services in the 1st trimester of pregnancy by 35%.

By 2022, increase the percent of pregnant women screened for gestational diabetes by 80%

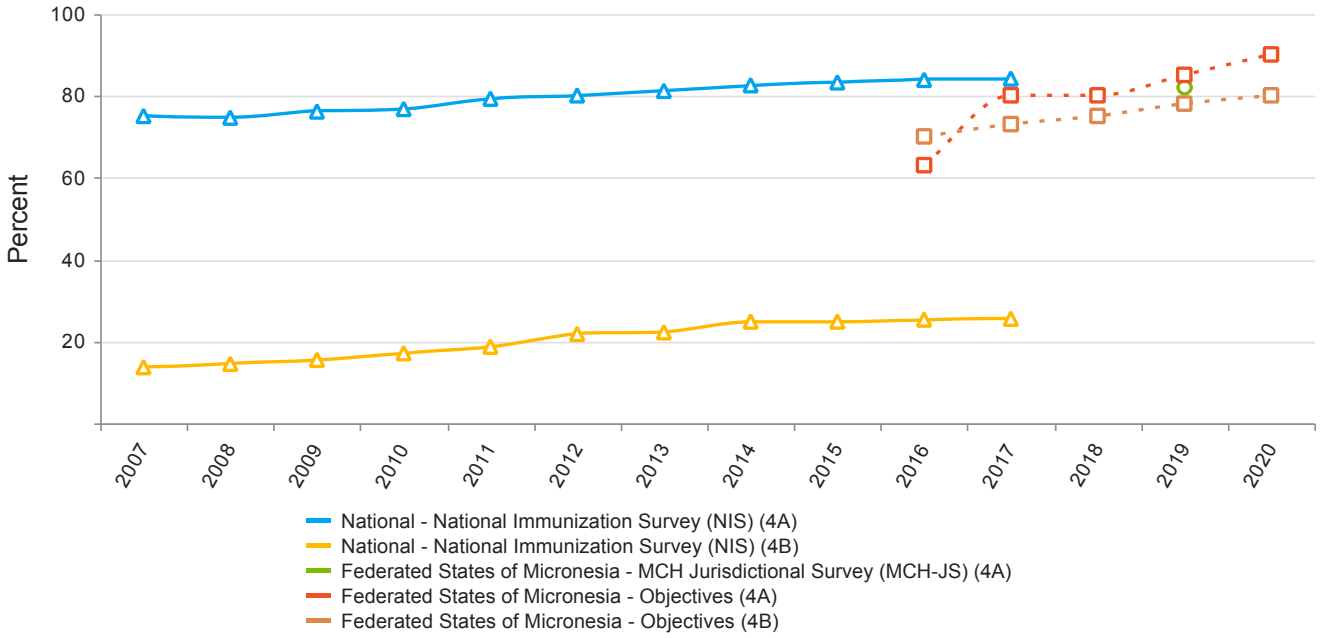
Strategies

To conduct at least 5 community awareness sessions (workshops, radio spots) on the importance of early pregnancy booking

Ensuring inventory of GDM testing is adequate and that GDM is included in the Prenatal procedure and manual

2016-2020: National Performance Measures

2016-2020: NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	85	90
Annual Indicator	81.9	81.9
Numerator	5,485	5,485
Denominator	6,694	6,694
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	63	80	80	85	90
Annual Indicator	0	0	0		
Numerator	0	0	0		
Denominator	100	100	100		
Data Source	-- State --	-- State --	-- State --		
Data Source Year	-- State	-- State	-- State		
Provisional or Final ?	Provisional	Provisional	Provisional		

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	70	73	75	78	80
Annual Indicator	69.7	59.9	70.7		
Numerator	1,359	1,173	1,336		
Denominator	1,950	1,958	1,890		
Data Source	MCH	MCH program	MCH program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Provisional	Provisional	Provisional		

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 4.2 - Percent of six months old exclusively breastfed.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		73	65	75	80
Annual Indicator	69.7	59.4	70.7	76.1	66.7
Numerator	1,359	1,155	1,336	1,511	1,237
Denominator	1,950	1,944	1,890	1,986	1,855
Data Source	MCH program and Birth Certificate	MCH program and Birth Certificate	MCH program and Birth Certificate	MCH Program and Vital Statistics	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 4 - Percent of infants screened for hearing

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		83	76	80	85
Annual Indicator	79.1	73	79.9	79	85.1
Numerator	1,599	1,512	1,589	1,552	1,560
Denominator	2,021	2,072	1,989	1,964	1,833
Data Source	EHDI program and Vital stats	EHDI program and Vital stats	EHDI program and Vital stats	EHDI program	EHDI program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: SPM 7 - Percentage of pregnant women with a first-trimester prenatal visit

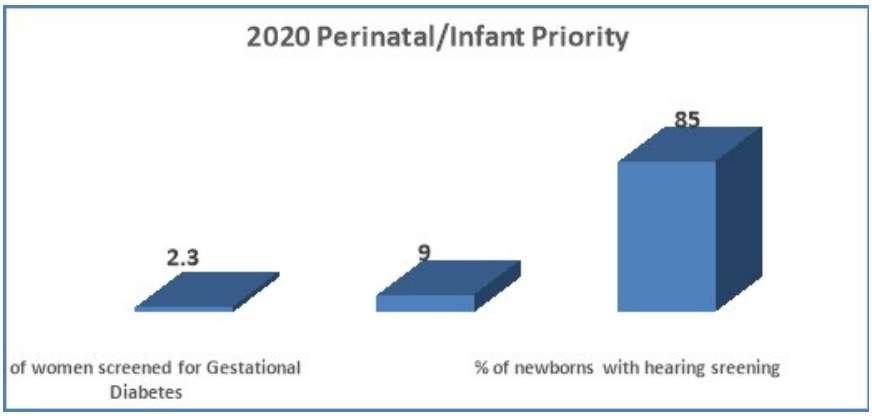
Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			50	60
Annual Indicator			30.6	30.6
Numerator			579	560
Denominator			1,890	1,833
Data Source			MCH program	MCH program
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Perinatal/Infant Health

Priority: Improve Perinatal/Infant Health outcome thru Gestational Diabetes, anemia screening during early and adequate prenatal services, hearing and anemia screening of the infant and promoting breastfeeding

The perinatal mortality rate in the FSM in 2020 was 37.2 per 1,000 live births, which shows an increase of 8.9 per 1,000 live births from 2019. The data continues to paint a scenario that unplanned pregnancy, late access and inadequate prenatal care, and poverty play a significant role in poor birth outcomes, causing additional stressors on the family, community, the health care system and the government. Lack of screening for gestational diabetes during prenatal care effects newborn outcomes. About 2% of pregnant women receiving services at the MCH program were found to have gestational diabetes in 2020. The MCH Program is committed to improving prenatal care access and adequacy through the MCH clinics and dispensaries in remote villages. In 2020 the NPM for exclusive breastfeeding through six months was decrease by 10% in women who are receiving services at the MCH programs in the States. This measure does not assess exclusive breastfeeding for the entire women of childbearing age population in the FSM. The qualitative reports from pediatric providers is that although women are still offering the breast at six months, most working women give bottled formula to their babes. Anemia is prevalent in the infant population of FSM as well as the childbearing woman population. In 2020, infants up to 1 year old who were screened for anemia were found to be at 9%, which is a decrease of 1.3% from 2019.

Most of the babies who were born in 2020 have had their hearing screening by OB nurses or MCH screeners. Overall, 85% of all newborns had hearing screening; 6% increase from 2019. The State MCH Programs reported problems with their screening equipment (OAEs) during OB screening, and further remedy was done on the screening equipment. Those that failed the initial hearing screened are required to return after two weeks for follow up screening. After passing the follow up screening, they are cleared from the list. For those who failed, they are referred for Diagnostic Audiological Evaluation (DAE) and await an appointment by the Audiologist. The MCH/CSHCN and Special Education Related Services Assistants (RSA) along with the Speech Pathologist continue to work with the parents in providing education and other support in an effort to reduce parental concern and anxiety about their children's conditions.



Chuuk State:

In 2020, the hearing screening is increased by 17% from 71% in 2019. There were more home births and loss to follow up babies referred to Well Baby Clinic at Public Health from Dispensaries, CHCs and the Public Health outreach team. Number of pregnant women attended prenatal clinic beginning of the first trimester increased by 6%. This was because of the accessibility of services at the CHCs in the rural areas. In addition to this, there was a good collaboration between MCH Program and the CHC in providing Antenatal services at their sites.

There was no workshop on breastfeeding conducted in 2020, because of the Covid-19 policies on social distancing,

this specific activity was postponed to this current year. So far there were 25 women from the communities who have been recruited and trained on Breastfeeding this year. 72% of babies in Chuuk were exclusively breastfeeding, which was slightly decreased from the previous year and this was because of the data source from the well-baby clinic that was counted, and other data source where not factor in.

Chuuk MCH Program will continue to decentralize the MCH essential services Antenatal care to the CHCs and dispensaries and to continue to collaborate with other public health programs to ensure all these essential services are well implemented. MCH is also planning to recruit more breastfeeding support groups from the communities, and continue to promote exclusive breastfeeding in the hospital and communities.

Kosrae State:

Percentage of pregnant women diagnosed with gestational diabetes remained 0% in 2020 and 2019. All pregnant mothers screened with GTT at first visit. It became a routine screening for prenatal clinic however intervention and treatment given early. Screening for gestational diabetes with GTT is currently in the protocol for prenatal clinic and it is part of the routine screening.

The percentage of infant breastfed up to six months of age increased to 78.9% in 2020 from 67% in 2019. The percentage of newborns screened for hearing before hospital discharge slightly decreased to 97% in 2020 from 98% in 2019.

The percentage of pregnant women used tobacco during pregnancy decreased to 0% in 2020 from 8% in 2019. Tobacco counseling and education were given to the pregnant mothers during prenatal clinics. There is a significant decrease in pregnant women who received dental screening in 2020 (36%) from 2019 (100%). Because of the Covid-19 pandemic, Dental services and schedules of the services were ceased. Dental staffs stopped coming to the Public health site on Tuesdays and Thursdays to do dental screenings and fluoride varnish. The percentage of pregnant women age 15 to 44 diagnosed with Syphilis slightly decreased to 0% in 2020 from 0.7% in 2019.

Kosrae MCH Program maintained the Breastfeeding Support Group. Breast feeding support group members follow up on mothers after delivery at their homes and provided One-on-One counseling session and education on breastfeeding at the home. MCH program nurse and counselor provide one-on-one counseling on breast feeding to new pregnant mothers during prenatal clinics and at two weeks postpartum. OB nurses provide one-on-one counseling session at the OB ward to those delivered before discharge.

All STI screening reagents, supplies were available including the lab top for the gene expert testing. Strong collaborations between programs and staffs still exist in the health arena. The syrup use for GTT screening is still not available however regular cola drink was the alternate.

Customary adoption, short period of maternity leaves and teenage student mothers were still the challenges for breastfeeding up to six months. In 2020, the Family Trac data system that collect, store and report newborn hearing screening was still a challenge because of the slow internet connections.

The MCH program plans to continue to utilize the breastfeeding support group members to do home visit follow ups and provide breastfeeding education at homes. Strengthen breastfeeding policies within the government and private sectors is highly recommended by the MCH program. The MCH program will continue to work with the department of Health to establish a Baby Friendly Hospital. It is request that there should be an external assessment and certification of Kosrae state hospital for Baby Friendly. In addition, it's requested that a law should be in place to prosecute those men who impregnant the teenage girls. The program will continue to procure hearing screening supplies and calibration of hearing screening machines. There is a plan to ask the FSM national government to provide a high-speed internet connection for Kosrae MCH program so it can improve the timeliness and need of MCH data systems in 2021.

Pohnpei State:

The decentralization of services and COVID-19 pandemic social distancing confused the people on where to received desired services thus decreased the number of patients seen for prenatal care beginning in the first trimester as well as regular visit. Planned community outreaches which included formalizing community breastfeeding support groups were cancelled so MCH staffs and OB nurses resorted to providing counseling on breastfeeding in clinics.

Prenatal first visit was one of the clinics recalled to Public Health for convenience of physician and service

requirements. Formalizing a breastfeeding support group to provide breastfeeding services was part of the community outreach activities that were canceled due to COVID-19 however, MCH staffs and OB and Pediatric nurses continue breast feeding benefits counseling and awareness in their clinics. Pohnpei State hospital is a certified Breastfeeding Friendly Hospital Initiative and breastfeeding up to 6 months was always encouraged at OB wards, Immunization, MCH clinics and Well baby clinics.

Because of COVID-19 social distancing planned community outreaches to visit communities and selected breastfeeding support groups were canceled. COVID-19 prevention activities continued took up most of the staffs' time with outreach awareness, vaccination and quarantine shifts.

Formalize Breastfeeding support group and continue provide one to one counseling on benefit of both breastfeeding and early prenatal care to mothers at OB ward, postpartum and well-baby clinic to all women and families who receive services from the MCH program.

Yap State:

Yap still does not have the breastfeeding support group. It was not possible to initiate the breast-feeding group due to the lack of available time and expertise to conduct training amid COVID19 prevention activities. Trainings of staff were focused on COVID19 prevention and activities. Unfortunately, the rate for exclusively breastfeeding babies at six months old could not reach the targeted 80%, but remained above 50%. Newborn hearing screening remained above 80% due to children born in Outer Islands who never had the chance to be screened.

Despite the lack of breastfeeding group and the limitation of the usual breastfeeding counseling, the rate of breastfed babies at 6 months of age remained above 50% during the year. At Public Health, breastfeeding counseling was only conducted during prenatal visits and post-partum clinics. At the CHC sites, more counseling was done with mothers who brought their babies in for immunization.

COVI19 pandemic has impacted all the services at health services. There was a government lock down, and interruption of clinics including the WBC. The department was all focused on COVID19 trainings and activities, so it was not possible to initiate the breastfeeding group. Training the selected members of the breastfeeding group would mean bringing in people from the public, and that was discouraged as to comply with COVID19 mass gathering and social distancing protocols. Further, babies who came for immunization were served at Public Health as walk in basis. Children who showed up for vaccination got their vaccination through walk in; counseling on breastfeeding was limited to the children observed to be thriving slowly.

Newborn hearing screening remained at above 95% for hospital discharged babies, but babies born in OI continued to miss out on this screening opportunity. A child with suspected hearing issues would only be referred to the main hospital for evaluation when he/she entered school with speech delay, via the school system referral. And at times, they were most likely beyond the age for proper management. Babies born in the Outer Islands who miss newborn hearing screening continued to prevent us from reaching this goal of 100% coverage. Further, one of the hearing equipment broke down leaving one machine to be shared between clinical and Public Health for screening. Due to boarders being closed to incoming visitors, the machines missed their calibration services.

MCH plans to conduct more outreach activities on promoting of breastfeeding in the communities and continue to promote breastfeeding in the clinics. With the recent situation, MCH will work with individuals to initiate the breastfeeding group. MCH wishes to purchase multiple user breast pumps for mothers to express breast milk for babies before going to school or work as this is one excuse for not exclusively breast feeding. MCH will support any activities to extend the maternity leave back to 6 months and initiate the breastfeeding group in the state current plan. MCH will work with the Health Assistants in the Outer islands to monitor children with suspected hearing defects and to make the referral for proper screening early in life.

Perinatal/Infant Health Plan – FY 2022

The NPM (Percent of very low birth weight infants born in a hospital with a Level III+ neonatal Intensive Care unit (NICU)) does not meet the situation in FSM as none of the FSM state Hospitals have NICU. Further, the NPM does not really relate to the priority, as the priority is aiming at early and adequate prenatal care while the NPM is focused on the outcome-neonatal care. Therefore, a state SPM (#1. Percentage of pregnant women who receive prenatal care services beginning in the first trimester) is created to address the need stated in the priority. Additionally, because the NPM only addresses one area in the priority (early and adequate prenatal care) the FSM MCH team thought a second SPM should be established to address the other need in the priority: (#2.To include gestational diabetes in the routine prenatal care and ensuring that all women are screened by 24-28weeks gestation. Anemia Screening is not included in this SPM as it is already addressed in the Women Health Domain. The current ESM (the percent of community clinics with extended service hours offering services to facilitate access to preventative visits) not only does it not correlate to the NMP and Priority, it also is something that MCH and the DHS have no direct control over. MCH is collaborating and partnering with other public health programs and the CHCs to serve the MCH Population. Therefore, the following strategies are created to properly address these needs of NPM and Priority:

Strategy 1. To conduct at least 5 community awareness sessions (workshops, radio spots) on the importance of early pregnancy booking.
Objective: To increase the rate of pregnant women receiving prenatal services beginning in the 1st trimester of pregnancy by 35%.

It is found during the needs assessment in 2020 that prenatal mortality rate for FSM is increasingly alarming over the last 3 years with 18.2 to 39.7 per 1000 births, with late prenatal access as one of the contributing factors. Therefore, there is a great need to educate the women on the importance of early prenatal care. This strategy will not only target the clients, but will also aim for the health care providers to be equipped with counseling information to be able to encourage women to come in for early prenatal services. To be a realistic and achievable strategy for the FSM, the target is set at 35% of pregnant women booked during their first trimester, as the trend for the last 3 years remained barely over 30%. During this COVID19 pandemic, this strategy can be done in any form (workshops, social media like radio spots or announcement) in the Communities, at the CHC sites or dispensaries. The minimum number of awareness activities is 5, but more can be done as the staff see fit.
Numerator/Denominator: Total number of pregnant women receiving services beginning in the first trimester/total number of pregnant women in the year

Strategy 2. 2a; Ensuring inventory of GDM testing are adequate.
Objective: To increase the percent of pregnant women screened for gestational diabetes by 80%

Strategy 2 addresses the other need in the priority-gestational diabetes screening. Most of the time, the pregnant women are not screened because, they show up to clinic very late in their pregnancy, the supplies are not available, or staff forget because it's not part of the routine services yet. Therefore, these strategies will ensure that these screenings become part of the prenatal procedure manual to ensure they are offered in a timely manner. The group leaves the aim at 80% (women screened for GDM) because all the states are still aiming for 100%, as this is fairly new, it takes time to revise manuals and protocols; and to be realistic for the outer islands (OI) situations as well. It would not be possible to reach 100% when the islands are still not equipped for this screening yet. Further, with the emerging issues of NCD in FSM, this objective is even more essential for early identification of diabetes in the pregnant women population, and the chance to prevent prenatal complications that may result from this health issue. Additionally, the rate of new confirmed GDM in FSM has remained above 2% for the last 2 years; even with the inconsistency in GDM screening in the nation as well as it being noted to contribute to poor perinatal outcome in the previous years. Hence, there is a great need for FSM to improve in gestational diabetes screening.
Numerator/Denominator: # of women screened for gestational diabetes and anemia / Total# of pregnant women

during the year

The MCH programs will ensure that these stated activities and objectives are met for the betterment of the perinatal services. Yap and Pohnpei have restarted their perinatal review committees in 2019, but due to COVID19 pandemic, it was not possible to continue with the activities. MCH is initiating the communication to revive the perinatal committees in the states because there is evidence that it improved the services in the OB clinic during its active period.

2022 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerator/ Denominator**
Perinatal/Infant Health				
Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	Percent of pregnant women who are screened for gestational diabetes by 24-28weeks.	By 2022, increase the rate of pregnant women receiving prenatal services in the 1st trimester of pregnancy by 35%. By 2022, increase the percent of pregnant women screened for gestational diabetes by 80%	To conduct at least 5 community awareness sessions (workshops, radio spots) on the importance of early pregnancy booking Ensuring inventory of GDM testing is adequate and that GDM is included in the Prenatal procedure and manual	Number of pregnant women at 20 to 24 weeks who are screened for gestational diabetes The total number of pregnant women during the reporting year.

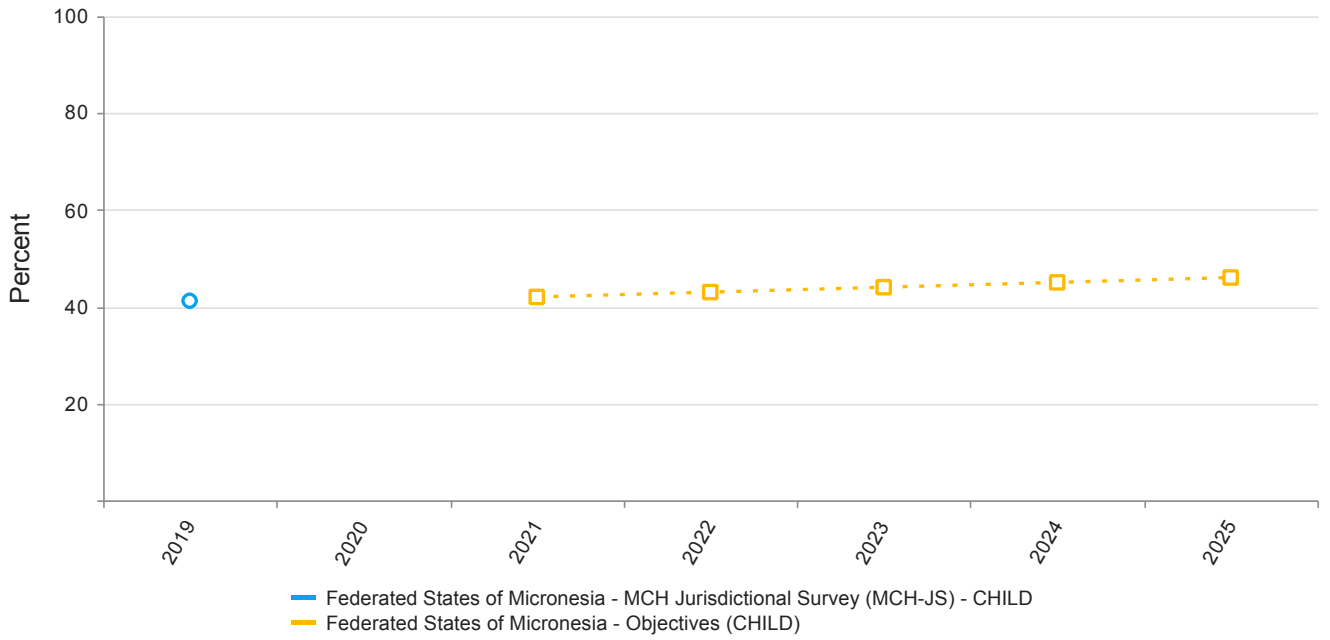
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	MCH-JS-2019	18.2 %	NPM 13.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	75.8 %	NPM 8.1 NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 10-17-2019	27.5 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC	Data Not Available or Not Reportable	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 8.1

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD		
	2019	**2020**
Annual Objective		
Annual Indicator	41.2	41.2
Numerator	2,724	2,724
Denominator	6,612	6,612
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	42.0	43.0	44.0	45.0	46.0	50.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Percent of children ages 6 – 11 years who are doing physical activities in schools at least 60 minutes daily before, during, and after the school day

Measure Status:	Active

Baseline data was not available/provided.

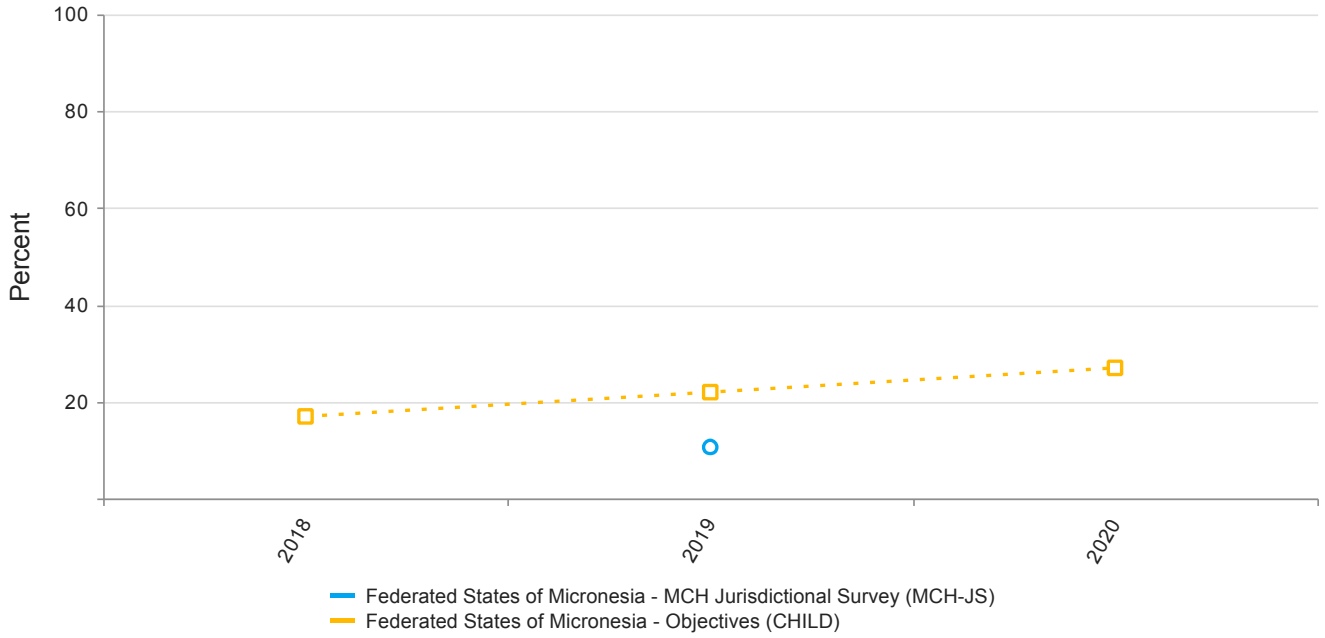
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	70.0	80.0	85.0	90.0	90.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Child Health - Entry 1	
Priority Need	
Improve child health through healthy weight through physical activity and nutrition promotion	
NPM	
NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	
Objectives	
Increase the percentage of healthy children through physical activity at least 60 min/day by 5% at the end of 2022	
Improve nutrition promotion and healthy weight among school children (6 – 11 years old) by 10% in 2022.	
Strategies	
To do educational awareness on healthy nutrition and physical activity among children ages 6 – 11 in the schools.	
ESMs	**Status**
ESM 8.1.1 - Percent of children ages 6 – 11 years who are doing physical activities in schools at least 60 minutes daily before, during, and after the school day	Active
NOMs	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	

2016-2020: National Performance Measures

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year Indicators and Annual Objectives



2016-2020: NPM 13.2 - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	22	27
Annual Indicator	10.6	10.6
Numerator	1,998	1,998
Denominator	18,899	18,899
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			17	22	27
Annual Indicator	9.4	11.9	27		
Numerator	1,861	2,320	7,555		
Denominator	19,766	19,543	28,003		
Data Source	Dental program and Census	Dental Health and Census	Dental program and Census		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Provisional	Provisional	Provisional		

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	50	30	40
Annual Indicator	9.4	46.9	0	54.1	78.3
Numerator	1,861	4,701	0	99	137
Denominator	19,766	10,020	100	183	175
Data Source	Dental program and Census	Dental program and Census	Dental program and Census	Dental program and Education	Dental program and Education
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

2016-2020: State Performance Measures

2016-2020: SPM 6 - Prevalence rate of 0-9 years old hospitalized for nonfatal injury/100,000

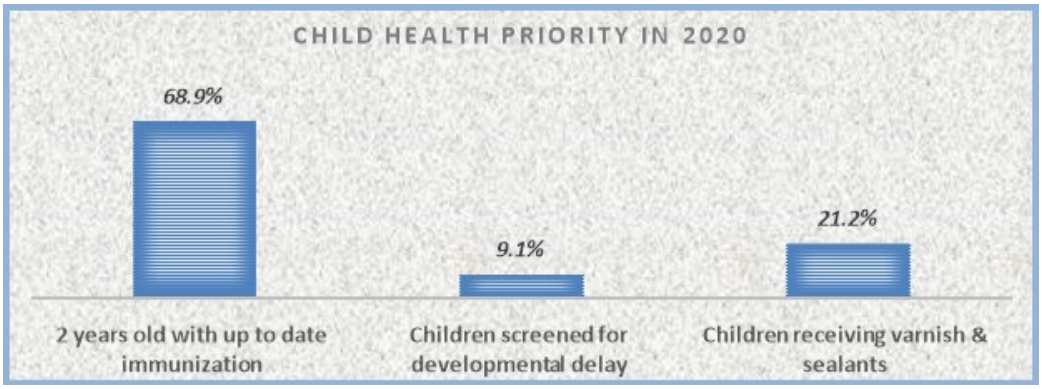
Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			500	400
Annual Indicator			392	547.8
Numerator			175	128
Denominator			44,643	23,368
Data Source			FSM MCH Data Matrix	Vital Statistics
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Child Health

Priorities: 1- Improve child health thru providing vaccinations and screening for developmental delays; Improve oral health of children. 2- Reduce childhood injury

Child vaccination in the FSM shows an increase in 2020 of 17% from the previous year. Although there is an improvement to child vaccination, yet there are still struggles to get all children to complete their vaccination. One of the main barriers for immunizations in the FSM is the need for refrigeration of the vaccines in the outer island dispensaries. This in itself hindered the provision of the vaccines in the outer islands, therefore, not reaching every child that are supposed to get their vaccines on time. The schedule of transportation is not reliable and often dependent on availability of the ships or patrol boat to cover the vast number of outlying islands in one trip. In Chuuk, Yap and Pohnpei, outreach services to the outer islands are only done once or twice a year which contributed to the low coverage for the three States. However, in Kosrae, vaccination is not a problem because there is only one island, and the population has accessibility to the health centers or the main hospital for their health preventive follow ups including child vaccination.

Currently, developmental screening is done routinely to babies from births up to 18 months old. This is due to the developmental screening tool that is available at the MCH programs to utilize in screening the children. No standardized tool exists beyond that age group. There is improvement on the children whose parents or caretakers were more participatory in the sessions for parental knowledge and awareness on the importance of avoiding risky behaviors, knowing the norms of normal developmental stages, and proper parental care. Interventions for those with developmental delays do not begin until age 3 with Special Education Program, therefore the MCH program provides the needed care and services for these children and parents. FSM does not have local Pediatric Cardiologists, Audiologists, and other specialists, thus rely solely on overseas contracts for specialty services for this population domain.



FSM children experience many non-fatal injuries. The rate of children who were hospitalized for non-fatal injuries in 2020 was 352.2 per 100,000 children ages 1-19 years old. Most of the injuries reported are falls related to play. FSM children enjoyed playing in their own natural island ways where it involves jungle racing, climbing trees and rocky cliffs, running barefooted on the sharp coral reefs or rocky areas, and many locally invented games that seemed risky and dangerous to many. There are no neighborhood facilities or playgrounds for children to play safely at.

Chuuk State:

In 2020, 100% of schools in Chuuk State were visited by the Public Health outreach team (MCH/Immunization, Cancer, PREP, FP and etc.) to provide Vitamin A and Deworming, vaccines (MR and MMR/Flu/HPV), and health awareness through IEC materials which included oral hygiene information. There were about 88% of children received information on oral hygiene and other health problems. Developmental delay screening continued to be part of MCH services provided at Well Baby Clinic and during outreach activities.

In 2020, only 7% of children received sealant and varnish, this was due to less activities conducted at the schools because of the covid-19 policies on physical distancing and so on. Dental staffs were not participated during the

visits to the schools because of the reason mentioned above. Screening tool for developmental delay is limited to certain ages (0-18 months only). FSM is still lacking developmental screening tools that can capture the screening information for children 19 months old and above.

Chuuk MCH Program will continue to work collaboratively with Dental and Behavioral Health in providing needed services in communities with health awareness on the importance of these services to the children. Chuuk MCH Program will continue to partner with Public safety and other public health programs in doing health awareness regarding child safety and substance abuse to young adults.

Kosrae State:

The percentage of 2 years old with up to date immunization is decreased to 87.7% in 2020 from 96% in 2019 in the State of Kosrae. Children screened for developmental delay is also decreased to 28.7% from 54% in 2019. The rate of children hospitalized for non-fatal injury increased to 1,526.72 in 2020 from 1,489/100,000 in 2019. The percentage of children received fluoride varnish and sealants increased to 90.5% in 2020 from 55% in 2019. The increase was due to a project sponsored by Kosrae CHC where school children were scheduled for Saturdays to come to the dental clinic for screening and varnished. The program provided transportation and incentives to the school children and the parents who attended the events.

A dental screening project was implemented in 2020 sponsored by Kosrae CHC in collaboration with the MCH dental assistant and the department dental staffs. Due to the pandemic some of the dental services were not carried out especially the school dental visits and other community outreach activities.

The developmental screening tool for the ages 2years to 5years old is still not developed yet. There was request to the Behavioral health programs to modify their screening forms used by the Linking Actions for Unmet Needs in Children's Health (LAUNCH program or request for TA to create a developmental tool to use for the CSHCN. The MCH program will continue the collaboration with the immunization program on all activities pertain to the Children population.

Pohnpei State:

Because of the Covid-19 pandemic, schools were enforced to close down before the actual end of school year season. Outreach clinics and awareness activities to schools and communities were interrupted in order to comply with social distancing and gatherings, thus decreased the number of schools and community visited to provide awareness and services by the MCH and Public health programs. MCH dental hygienist was able to visit only 28 schools (Elementary, Kindergarten and Private) and provided oral health preventive services and awareness before schools completely closed down in early March of 2020. Child injuries had decreased probably due to closing of school and community gatherings. Unintentional injuries happened mostly on school playgrounds and during community gatherings. The MCH program will continue to collaborate with public safety to promote injury safety measure and provide awareness in the schools and community gathering once the regulation on social distancing is lifted. Schools outreach clinics and awareness activities were interrupted due to early closing of schools.

Yap State:

The MCH Dental staff was brought in to join in the school health activity, splitting the work with the CHC school health, who only visits the schools in their catchment areas, thus increase in the number of schools visited during the year. However, due to COVID19, dental clinics were also closed eliminating the chances for individual dental appointments for children not in school.

School Health continued this year with the collaboration of multiple programs: MCH, Immunization, Cancer, CHC, CSR and Dental services. There was a need of more collaboration to ensure that all the necessary services were delivered at one visit to comply with the COVID19 regulations of mass gatherings and social distancing. More schools were visited (36%) of primary schools that had dental visits during the year including some schools in the Outer Islands. Further, with the generous support of UNICEF, hygienic supplies, (toothpaste/tooth brush, soap, and sanitary pads) were received just in time for school health so they were distributed to the students and the schools as incentives. Some of the supplies were delivered to some of the Outer Island schools with the help of Catholic Religion Services through Okeanus agency.

The decrease in preventative oral care was due to the lesser outreaches and cancelation of dental clinic visits. Children who attended WBC were always referred to dental for fluoride varnish, but with the cancelation of WBC at PH, this referral was also disrupted. There still only one dental staff in one of the islands in the Outer Islands; the rest of the islands only receive dental services when dental staff visit the islands during field trips.
MCH will continue to work closely with all the relevant agencies for the continuation of school health activities, especially with the DOE/ECE, CHC, Immunization program and Dental division. MCH will continue to support in supplementing supplies to dental division and re-instate the WBC children referral for fluoride varnish. MCH is now initiating collaboration with UNICEF regional Office and Education on Wash in school Program.

Child Health Plan – FY 2022

Obesity in children is becoming a very prominent issue in the FSM with very few opportunities for physical activities in the younger children. It's also unclear if the schools are safeguarding adequate and effective lessons on the importance of good nutrition and physical activities. Aside from school activities or annual events that call for sports competition among the municipalities, there are no set programs that run throughout the year for sports and/or physical activity to help ensure our young ones stay fit and healthy. In this day and age, imported foods serve as the easiest options for families with working mothers. Unfortunately, the easiest options are most likely not the healthiest. This had let to the obesity problem in the country along with the lack of or very little knowledge on the importance of good nutrition – thus led to the choosing of this priority - The priority for the Child Health Domain is to improve child health through healthy weight with physical activity and nutrition promotion. The selected NPM for this priority is the percentage of children ages 6 – 11 who are physically active for at least 60 minutes per day. The initial objective was to increase the percentage of children under 6 – 11 who are physically active for at least 60 min/day by 5% from the baseline data by the end of 2021. However, this will not completely reflect the priority because the nutrition promotion aspect is excluded. In turn, two objectives were created:

1) Increase percentage of healthy children under 6 – 11 through physical activity at least 60 min/day by 5% at the end of 2022;

2) Improve nutrition promotion and healthy weight among school children (6 – 11 years old) by 10% in 2022.

By doing so, not only will we help tackle the obesity issue among the young children, but it will also tie well in to FSM fight against NCD as mandated in each State - the State of Emergency Declaration. The strategy for the national performance measure is: To do educational awareness on healthy nutrition and physical activity among children ages 6 – 11 in the schools. There is still a lack of nutritionist on island, however, clinicians and health workers alike can aid in creating well-informed radio program or awareness campaign on good nutrition. Since the School Health Program visits all schools every year, said clinicians or health workers who are more knowledgeable about nutrition can accompany the program to simultaneously provide educational awareness that is specifically catered to this age group. SPM's are done away with since both objectives embody and highlight all the important aspects of the priority. The evidence-based measurement for this particular domain would have to be looking at percentage of schools providing physical activity opportunities at least 60 minutes daily for its students before, during and after the school day. Activities can be anything from P.E. classes to extracurricular activities that involve the children being active for 60 minutes straight or in interval times that add up to 60 minutes. The numerator would be number of schools providing 60 minutes daily activities to 6 – 11 yrs. old with total number of schools in the state as the denominator. Sources of data can be DOE, School Health Program and NCD Program. DOE data can be obtained by reviewing primary school curriculum or via active collection by visitation or calling each school directly; MCH staff accompanying School Health program and NCD program during primary outreach activities can also serve as an opportunistic time to collect much needed information/data.

2022 FSM MCH ACTION PLAN					
Domain and State Priority Needs	**NATIONAL PERFORMANCE MEASURE**	**Objective**	**Strategies**	**ESM**	**Numerator/ Denominator**
Child Health					
Improve child health through healthy weight through physical activity and nutrition promotion	NPM 8.1 Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day	Increase the percentage of healthy children through physical activity at least 60 min/day by 5% at the end of 2022	To do educational awareness on healthy nutrition and physical activity among children ages 6 – 11 in the schools	Percent of children ages 6 – 11 years who are doing physical activities in schools at least 60 minutes daily before, during, and after the school day	Number of children ages 6 – 11 years who are doing physical activities in the schools at least 60 minutes daily
		Improve nutrition promotion and healthy weight among school children (6 – 11 years old) by 10% in 2022.			Total number of children ages 6 – 11 in the schools

Adolescent Health

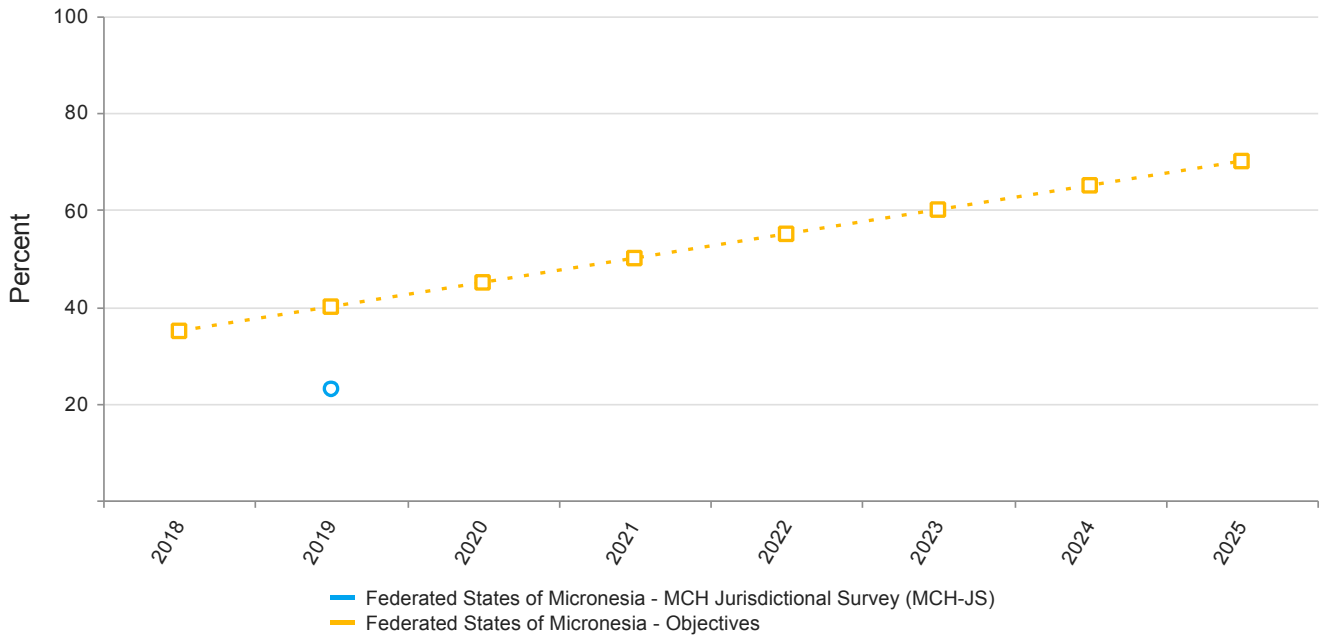
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	0 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	75.8 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 0-2	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	MCH-JS-Age 10-17-2019	27.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC	Data Not Available or Not Reportable	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	13.2	NPM 10

National Performance Measures

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



Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	40	45
Annual Indicator	23.2	23.2
Numerator	1,680	1,680
Denominator	7,251	7,251
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			35	40	45
Annual Indicator	0	0	0	23.2	
Numerator	0	0	0	1,680	
Denominator	100	100	100	7,251	
Data Source	-- State --	-- State --	-- State --	State	
Data Source Year	-- State	-- State	-- State	State	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of adolescents ages 12 through 17 attending educational awareness on preventive medical visits in the schools

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			35	38
Annual Indicator			61.5	78.3
Numerator			99	137
Denominator			161	175
Data Source			MCH program and Education	MCH program and Education
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	60.0		

State Performance Measures

SPM 4 - Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Adolescent Health - Entry 1	
Priority Need	
Improve health promotion communication	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
By 2022, increase the percentage of students ages 12 through 17 who have a preventive medical visit by 25%	
Strategies	
Provide educational awareness in the schools on preventive medical visits	
ESMs	Status
ESM 10.1 - Percent of adolescents ages 12 through 17 attending educational awareness on preventive medical visits in the schools	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Federated States of Micronesia) - Adolescent Health - Entry 2

Priority Need

Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e drug, alcohol use) and poor outcome

SPM

SPM 4 - Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools

Objectives

By 2022, increase the percentage of adolescents that receive a well-adolescent visit that includes assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior and poor outcomes by 25%.

Strategies

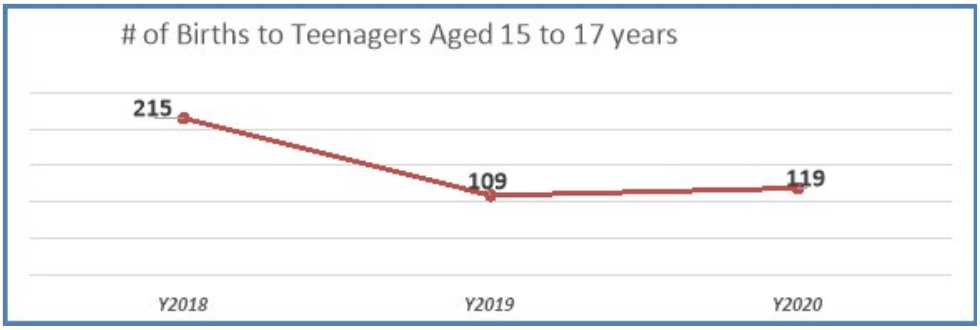
To provide educational awareness in all the schools on the importance of well medical check-ups or health preventive visits.

Adolescent Health

Priority: Decrease incidence of teenage pregnancy and STI

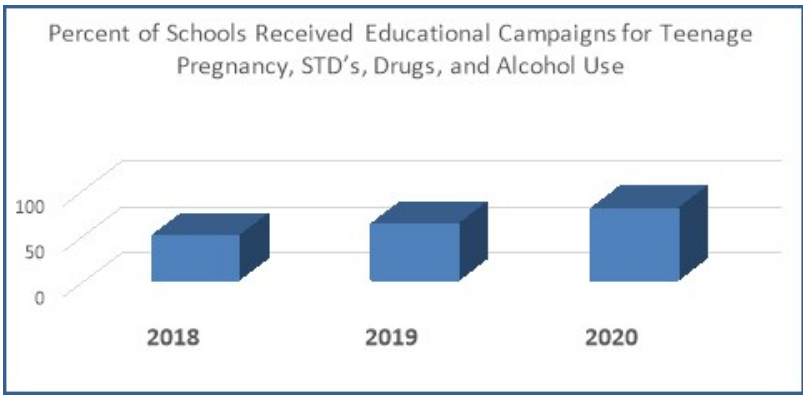
The FSM teen birth rate in 2020 was 38.7 births per 1,000 females ages 15-17; an increase of 2% from 2019 MCH data reported on teen pregnancy. High-risk sexual behaviors among adolescents are a significant public health concern in the FSM. These behaviors account for increasing rates of premature morbidity and mortality by contributing to risk of unintended teen pregnancy, HIV/AIDS, and other sexually transmitted diseases.

It is customary in most of the FSM States to bear children at a young age. In Pohnpei, the legal age of consent is 18 years old. In Yap, the legal age of consent is 13 years old. Chuuk has increased the legal age of consent from 13 to 18 years old. Teen mothers are less likely to finish high school and have low school achievements, drop out of high school, and were burden to their families as well. Cultural and socioeconomic factors may influence high-risk sexual behaviors, which may, in turn, increase risk for STDs, unintended and teen pregnancies. The rate of sexually transmitted diseases (STDs) and HIV/AIDs in the FSM is still a problem.



The MCH Program is currently working with youth groups in each State to reach the adolescent population. Such groups are Youth for Change in the states of Chuuk and Yap. Chuuk Youth Council, and the Public Health PREP-Personal Responsibility Educational Program to encourage positive health behavior activity in adolescents, through comprehensive interventions at age-appropriate levels in a culturally-sensitive manner that will impact the frightening possibilities of unplanned pregnancy and teen birth, sexually transmitted diseases in the adolescent and young adult population, alcohol and drug use. Marijuana and alcohol usage were obvious in youths and older peoples with pressures that create more problems and difficulties in the families and communities. There is lack of law enforcement on the sales of alcohol, and many businesses in the FSM sell cheap alcohol to the young adults which in turn contributed to the spread of STI's among adolescents and increase percentage of teen pregnancies in the young girls.

Although the behavioral risk factors in the adolescent population seems to increase during the reporting year, yet the MCH programs in the states are still reaching out to this population through information dissemination strategies and awareness activities in the schools.



Chuuk State:

In 2020, 100% of the middle schools in Chuuk was visited by the MCH and other Public health programs. All Public Health programs were part of the campaigns in all the school in which they provided MMR vaccines, HPV vaccinations and de-worming medicines. IEC materials on (STDs including HPV, Teen pregnancy and substance abuse) were also distributed to students during the visits. The data also showed that the number of teen pregnancy (ages 15-17) reported also decreased by 26 %. This is due to the health awareness conducted in the field by the MCH and other Public Health program partners.

In 2020, Accident and suicide rate in Chuuk continue to be an issue, this is due to the fact that alcohol and drug (Marijuana, propane/Gas inhalation/kava, betelnuts) use were very common in the communities which influence and entertain many youngsters. Loss to follow up on our positive STD clients was also a challenge, and this was because of the migration of people within the state and abroad.

MCH Program will continue to work collaboratively with Public Health program partners, NGO partners, Dept of Education and the College of Micronesia in doing public awareness on health issues that are affecting adolescence health.

Kosrae State:

The percentage of schools that received educational awareness on teenage pregnancy, STDs, alcohol and drug abuse and healthy lifestyles remain at 100% in 2020 similar to 2019. The rate of suicide among adolescents remained 0 in 2020 and 2019. The rate of mortality in adolescents due to motor vehicle accidents remained 0 in 2020 and 2019. In 2020, the rate of teenage pregnancy tremendously increased to 43.5/1,000 from 1.4 in 2019. All of these pregnancies were single teens. Most of them were left by their parents on island, unsupervised, while parents seeking medical help and jobs abroad.

All the 7 schools in Kosrae (public and private) received educational awareness on teen pregnancy, STI, alcohol, tobacco used and healthy lifestyles which were provided by the collaborative public health programs. Kosrae state department of education is still lacking curriculum for family life education at the secondary level.

Due to Covid 19 community awareness education workshops on this domain was not conducted.

Kosrae MCH program will strengthen programs at the public health and groups in the communities that provide all the education and counseling in the future after the fact that the pandemic is over. Continue the collaboration between programs and other agencies to do awareness and education. Working with department of education to create curriculum for family life education is in plan for the program to do in next years' activity along with more parental education on the prevention of teenage pregnancy.

Pohnpei State:

The closing down of schools due to COVID-19 had affected schools activities causing a decline in the number of schools visited to provide awareness and services on adolescents' health. Schools locked down had also prevented the continuity of school health awareness in the schools for the school year.

In 2020, prior to close out of the schools, collaboration of health teams along with MCH were able to provide HPV vaccinations and sexual health awareness to 28 schools in the state of Pohnpei. Changing of Lifestyle encourages

teen pregnancy and STI, which involves parents accepting their young ones to go on unsupervised courting which ended up in teen pregnancies.
The 2020 data showed a decrease of 33.8/1,000) from 40.6/1,000 birth to teenage mother ages15-17 years old. This is probably due to the Law on Age of consent where perpetrators are punishable by law.

The MCH program will continue to collaborate with STI and School Health programs to provide awareness on STI and Age of Consent Law to increase the public knowledge and understanding on the regulations and laws on STI and Teen pregnancy. Since FSM is still COVID-19 free, outreach and awareness from the public health teams will still be going on. All Covid-19 preventive measures will be observed during outreaches on these health awareness issues.

Yap State:

Teenage pregnancy has declines from 26.5/1000 in 2019 to 12.1/1000 in year 2020. Schools were targeted during the pandemic for education, and MCH took the chance to get involved in the planning to ensure school health is part of this one time visit to the schools. Multiple agencies and programs worked together to serve the adolescent population such as the Cancer program, Immunization program, FP program, PREP, and other NGO groups as CRS and Red Cross. With every school, Cancer Program took the liberty to educate the students on HPV and other youth issues as teen pregnancy, STI and other risky behaviors. Procurement of the MCH vehicle was a big assistance to the program's outreaches as in school visits and other community activities. Amid the COVID19 activities, School Health continued and this year with additional focus on proper hygiene and COVID19.

Even with the 30% of primary schools enrolled into the PREP program, there was still a significant percentage of STI in the youth group (21.7/1000) and teen pregnancies (12.1/1000), the youngest as low as 14 years of age. HPV coverage dropped a little but it was only due to the few that refused the vaccine. Outreach activities were only done in the schools, but it was not possible to do community outreaches during the year due to COVI19 challenges and activities. Resources for school health are limited to Primary and ECE schools currently. High schools were visited only with invitations or other health activities in the schools. Extending this school health visits to the high school levels will greatly impact education awareness to this age population.

MCH will continue to join and support all Public Health activities on Main Island and in the Outer islands, to reach out to this age population by visiting schools in the state to educate on teen pregnancy prevention, STI and drug and alcohol use awareness. MCH will continue to work with FP for emphasis on teen pregnancy prevention; STI Programs to reduce the incidence of STI in the youth group, and with Cancer program to educate on cervical cancer and the benefits of the HPV vaccine. MCH will continue to work closely and support PREP program to conduct their curriculum in the schools.

Adolescent Health Plan – FY 2022

The new SPM under this domain is “Percent of adolescents aged 12-17 years old who have attended educational awareness sessions on adolescent behavioral health in the schools” and the strategy for the SPM is to provide educational awareness on adolescent behavioral health and risk behavior in all the schools so that the students can be able to make wise decisions and be able to prevent themselves from all the risk behavior activities that they are engaged in such as drugs and alcohol use, multiple sex partners, unprotected sex which can lead to STIs, teen pregnancy, injury and accident. MCH will continue to work closely with PREP, BH&W and other program partners, Dept. of Education in promoting healthy behaviors and risk behaviors for adolescent in all the schools in FSM.

The preventive strategic measure that FSM would like to implement next year with the adolescent domain is the environmental strategies on information disseminations and educational awareness in the secondary schools on teenage pregnancy, STD’s, drugs, and alcohol use. The objective is to increase the percentage of adolescents that receive a well-adolescent visit by 25% by the end of 2022. FSM still needs to improve adolescent health through continued efforts with other programs on promoting healthy behaviors and and reducing risk behaviors. The FSM MCH and Family Planning Programs will to continue work closely with the school administrators in the states to incorporate the sexuality and family life education in their school curriculum which were developed in under the United Nations Fund for Population Activities. This effort is made specifically to prevent the high rate of teen pregnancy by propagating healthy lifestyles.

The age of consent for marriage in the FSM in the past years was 13 years of age. With the support of other collaborated entities and programs, laws on consent age of marriage in the states was increase to at least 16 and 18 years of age. The FSM MCH Program plans to strengthen and focus its awareness and educational programs to families, traditional leaders, religious leaders and law makers on issues pertaining to adolescent’s healthy behaviors and risk behaviors. The FSM MCH and Family Planning Programs plan to strengthen its partnership with the STI and HIV/AIDS Programs and Red Cross so Condoms are available at many more community locations and accessible to adolescents throughout the FSM. The FSM MCH Program plans to continue working with the Substance Abuse and mental health program to continue doing more awareness and education around suicide, its causes and prevention. During adolescents well visits outreaches, youth will receive information and education on risky behaviors and its possible negative outcomes as well as healthy behaviors.

2022 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerator/ Denominator**
Adolescent Health				
Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug, alcohol use) and poor outcome	Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools	By 2022, increase the percentage of adolescents that receive a well-adolescent visit that includes assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior and poor outcomes by 25%.	To provide educational awareness in all the schools on the importance of well medical check-ups or health preventive visits.	Number of 12-17 years old attended education on adolescent's health during the past school year Total number of 12-17 years old in the Schools

Children with Special Health Care Needs

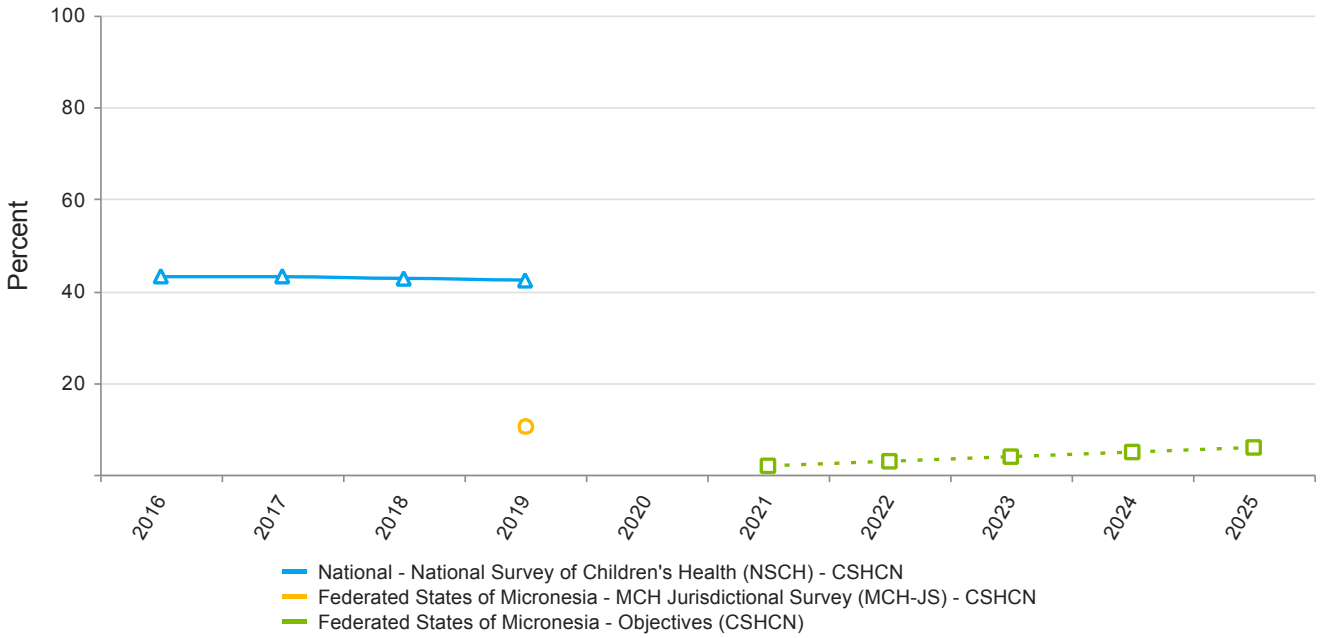
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	MCH-JS-2019	0 %	NPM 11 NPM 12
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	MCH-JS-2019	0 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	MCH-JS-2019	75.8 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	MCH-JS-2019	8.5 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH	Data Not Available or Not Reportable	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	10.4	10.4
Numerator	167	167
Denominator	1,607	1,607
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	2.0	3.0	4.0	5.0	6.0	10.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CSHCN providers and parents/caregivers received components of the medical home training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective						

State Performance Measures

SPM 5 - Percent of parents/caregivers receiving training on specialty care for children with special health care needs (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Children with Special Health Care Needs - Entry 1	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2022, increase percent of Children with special health care needs with a medical home by 5%	
Strategies	
Work with experts to provide a complete component of the medical home training to providers and parents/caregivers.	
ESMs	Status
ESM 11.1 - Percent of CSHCN providers and parents/caregivers received components of the medical home training	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

State Action Plan Table (Federated States of Micronesia) - Children with Special Health Care Needs - Entry 2

Priority Need

Provide care coordination training for parents/caregivers of Children with Special Health Care Needs

SPM

SPM 5 - Percent of parents/caregivers receiving training on specialty care for children with special health care needs (CSHCN)

Objectives

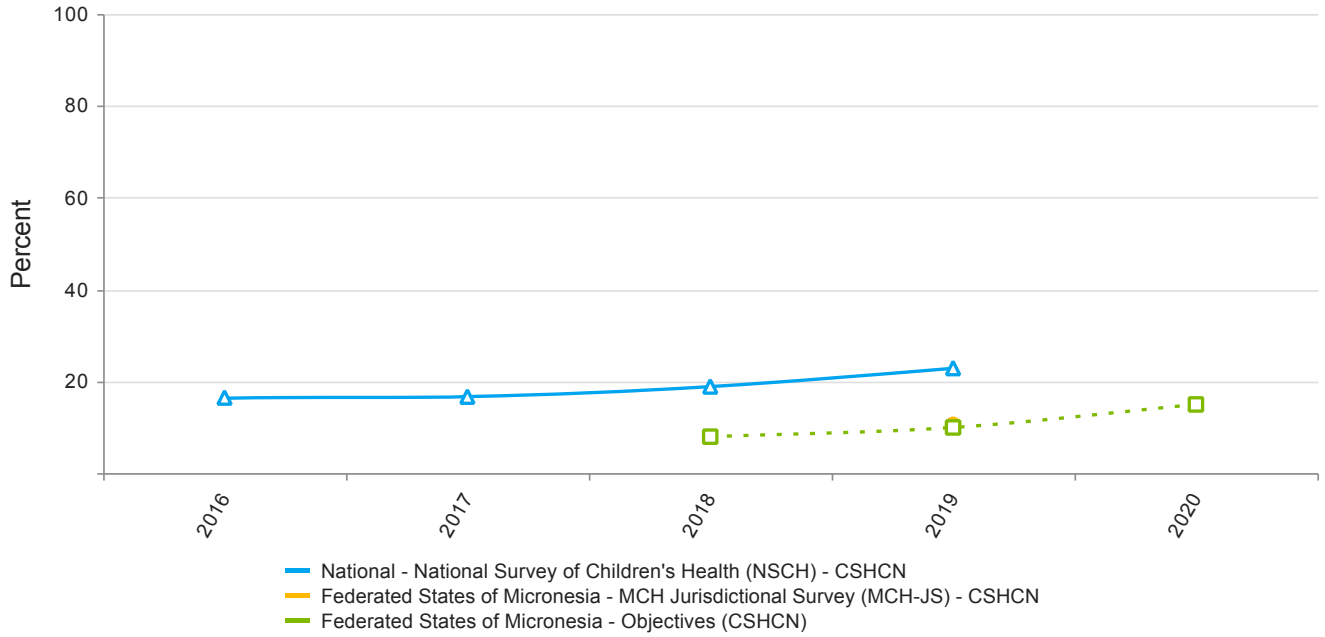
By December 2022, increase the percentage of parents/caregivers receiving specialty trainings on CSHCN care coordination by 5%.

Strategies

Work collaboratively with specializing trainers to provide training to CSHCN parents/caregivers in the States

2016-2020: National Performance Measures

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



2016-2020: NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	10	15
Annual Indicator	10.4	10.4
Numerator	70	70
Denominator	676	676
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			8	10	15
Annual Indicator	2.4	5.5	1.4		
Numerator	46	86	21		
Denominator	1,910	1,551	1,462		
Data Source	CSHCN program	CSHCN program	CSHCN program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Provisional	Provisional	Provisional		

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	15	30	35
Annual Indicator	2.4	1.3	0	17.8	80.8
Numerator	46	18	0	173	1,503
Denominator	1,910	1,414	100	972	1,860
Data Source	CSHCN program	CSHCN program	CSHCN program	CSHCN program	CSHCN program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Children with Special Health Care Needs (CSHCN)

Priority: Provide a transitional service for youth identified as having Special Health Care Needs

According to the FSM State MCH programs, about 2% youths out of the 1,856 registered CSHCN clients had received transitional services in 2020. The 30 children that transitioned in 2020 were put on employment and continued working at convenient stores, gas stations, etc. Development Skill Program (ADSP) provides children with special health care need services/jobs when transition from High schools and college. Special Education provides some kind of supports and services to the mothers of CSHCNs. Special education conducted annual evaluation for mothers and their children to assess effectiveness of their services to the CSHCN children. About 1,900 children were identified and enrolled in the CSHCN program and Health services for follow up and treatment or management. Among these population were children with rheumatic heart diseases and children with hard of hearing, and etc. The target for 2020 was set at 15%. However, only 1.7% of adolescents with and without special health care needs received services necessary to make transitions to adult health care compared to 1.5% in 2019. Health Services department does not have employment program services that may help these adolescents' transition into adult life. The MCH programs relies on transitional services done by the department of education (special education); after all information are documented and being shared with the MCH program on those CSHCN clients.

FSM CSHCN programs still encounters challenges and limited services in the CSHCN area. Several of the limitations are: Lack of CSHCN specialty services, Limited rehabilitation services, Limited job opportunities for the CSHCN youths and No MOU (other than special education) established with other entities who could provide services to the CSHCN population.

Chuuk State:

In 2020, two of the CSHCN youth continued to work as regular staffs at the Dept of Education. Chuuk MCH/CSN Program continued to work collaboratively with the Special Education Program and partner with NGO (Kichable) in doing awareness on the CSHCN rights and accessibility of services to the CSHCN population. Program staffs along with the NGOs partners continued to lobby with the Legislature to enact Laws on accessibility for disability people.

There are no specific tracking data system on transitioned CSHCN clients. Several parents of CSHCN clients are not informed of the type of services available for their children, despite of all the awareness being provided to the public by the MCH and SpEd programs.

MCH/CSHCN Program will continue to work collaboratively with the Program's partners (SpEd) and NGOs partners (Chuuk Kichable Association/CWC) in providing health awareness regarding this specific population domain and continue to strengthen transition services for them.

Kosrae State:

The percentage of youth with special health care needs who are employed increased to 21.4% in 2020 from 0% in 2019. Kosrae state Inter agency council reorganized this year and it's been very active and had been collaborated strongly with the Kosrae special parent network

Kosrae still experienced the lack of specialty and rehabilitation services for the CSHCN group in the State.

The plan to incorporate in next year's activities is to strengthen programs that provide transitional services and rehabilitation services, and support efforts to improve policies and practices for the CSHCN population.

Pohnpei State:

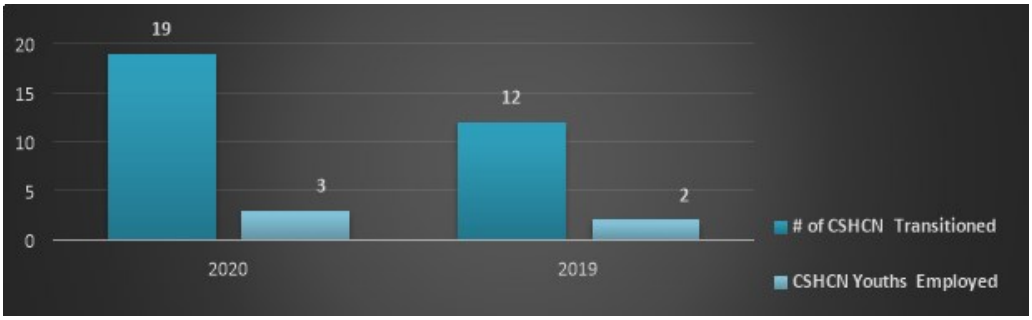
COVID-19 pandemic has affected all programs including Special Education who provide services to CSHCN children when schools closed down. This interruption of service had contributed to the declined in the number of CSHCN evaluated and transition out from the CSHCN program.

In Pohnpei, twenty-seven (27 or 11%) CSHCN received transitioned to nonmedical services before school completely close down. Workforce Development & Skills Training Program (WD&STP) continued to provide these children jobs when transitioned from High schools and colleges.

COVID-19 pandemic had restricted and cancelled planned school activities as well as community services and health awareness. Staffs were also assigned to covid-19 prevention activities at the health services and communities and these has delayed other activities that are supposed to be for the CSHCN population group. One of the objectives under the CHSCN domain is to work collaboratively with SPED and other agencies to strengthen transition services, and this should be implemented fully once the restrictions on Covid-19 is lifted and activities are back to normal.

Yap State:

Nineteen (19) CSHCN youths exited the program in 2020 and among them; only 3 were employed through the Special Education transition program. MCH has yet to collaborate with the Yap Job Placement Program to seek the possibility of finding employment for these clients who exited the CSHCN program and may be qualified to join the work force.



MCH and in collaboration with Special Education Services ensures that clients are ready to exit the programs. MCH/CSH offers partial free charge medical follow up annually, (more frequent if need to) and Special Education offers employment thru their transition program to those willing and able to seek other sources of income. Nineteen (19) clients were discharged from the program with only 3 employed through Special Education services. Two were assisted for self-employment (sell home garden produce) and one was employed at one of the private businesses. Further, through the EHDI program, and the existence of tele audiology, three children with hearing impairment were very fortunate to acquire hearing aids and speech and language counseling. One child with permanent hearing was able to hear sound for the first time in his 7 years of life. Additionally, a parent group was formed with six families served as members.

Because MCH does not have transitional program, once a child is of age, he/she is dropped from receiving CSHN free services at the hospital. MCH relies on SPED transition program to help these clients find other source of income once they exit the program. It was difficult to collaborate with the Yap Job Placement program because of the COVID19 restrictions. The most appropriate way to assist these youths was to direct them to services that may be of help to the clients and their families, such as Behavioral Health, visiting specialists, and social security programs. Some clients are out in the Outer Islands, with no physician to monitor their health care needs. Some needed to be referred to the main hospital for follow up with visiting specialist but could not come down due to financial constraints. They are somehow neglected out in the islands.

Yap still does not have a pediatrician to look over the clinics. Clients see any doctor available; therefore, continuation of care is inconsistent with multiple doctors overseeing the clinic. Sometimes appointments needed to be cancelled due to the lack a physician. This has been a long-standing problem for the state.

MCH will work closely with Special Education to ensure that the best services possible can be given to this special population group before they exit the programs. MCH will continue to refer clients to other agencies, and groups that can offer any help possible to these youths with disability. MCH will work with Yap Job Placement Program to seek the possibility assisting these youths find employment after exiting the program. It would be really great to have a “skill developmental center” built in Yap where these youths can be guided in honing their skills; learn a sustainable skill that leads to independence. There is no such center or organization that helps in this area so the best and realistic way is to collaborate with other agencies that can help these children after they are aged out of CSHN and Special Education services. MCH/EHDI will continue to work remotely with the EHDI consultants to screen children with hearing development and issues.

Children with Special Health Care Needs (CSHCN) Plan – FY 2022

In the four states, an interagency agreement for the CSHCN Program has been developed that involves the CSHCN Program, MCH Program, the State Hospital, the Dept of Education, Special Education Program, the Early Childhood Education Program, and the Parent Network. This interagency agreement has been established to assure that children are screened for disabilities, and those who are suspected of having a disability are referred to the CSHCN Program for an assessment.

The FSM Dept of Education, in particular the Early Intervention Service, is an essential partner of the CSHCN Program. Most of the CSHCN kids were referred by Special Education, and collaborative work and trainings in the CSHCN arena was a strength among the two agencies. Since FSM does not have experts and specialist in the field, the focus of MCH's needs assessment this year is to work collaboratively with specializing trainers in the CSHCN field to provide training for parents/caregivers in the States so skills and knowledge on CSHCN clients should be improved. It is also the goal of the MCH programs to increase number of trainings to providers and facilities providing CSHCN services to families and CSHCN clients.

2022 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerato Denomina**
Children with Special Health Care Needs				
Provide care coordination training for parents/caregivers of Children with Special Health Care Needs	Percent of parents/caregivers receiving training on specialty care for children with special health care needs (CSHCN)	By December 2022, increase the percentage of parents/caregivers receiving specialty trainings on CSHCN care coordination by 5%.	Work collaboratively with specializing trainers to provide training to CSHCN parents/caregivers in the States	Number of parents/careg receiving trai on care coordination CSHCN Total number parents/careg during the reporting yea

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

Cross Cutting/System Building Domain

There was no plan for this Domain in 2020 therefore there is no annual report provided.

Cross-Cutting/Systems Building - Application Year

Plan Cross Cutting/System Building Domain

FSM does not have any plan for this Domain in next year’s application

III.F. Public Input

DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS

FSM National Government
Capitol Street, P.O. Box PS 70
Palikir, Pohnpei 96941
Federated States of Micronesia

Tel:(691)320-2619/2643/2872 ●E-mail: health@fsmhealth.fm ●Fax: (691) 320-5263

August 20, 2021

PUBLIC SERVICE ANNOUNCEMENT

FSM National Government, Department of Health & Social Affairs wishes to announce to the General public that the Title V Maternal and Child Health (MCH) Block Grant Application for FY-2022 will be ready and available for public review and comment starting August 31, 2021. The information on the MCH Grant Application will be posted at various public sites for interested individuals to also review and provide comments. The FSM MCH Program will do the final review of the grant application after the Grantees Block Grant Review in December 2021. Those who are interested to review this application can provide comment and feedback to below contact information. You can also send self-returned envelope to the following address or contact us by telephone or email.

FSM National Government Department of Health and Social Affairs
Attn: MCH Program
P.O. Box PS 70 Palikir, Pohnpei FM 96941 Phone: (691)320-2619/2643/2872
Email: desaimon@fsmhealth.fm or health@fsmhealth.fm

Thank you for your support in ensuring that we provide good and appropriate health care to the children. mothers, and their families throughout the FSM. We look forward to receiving your feedback.

Mr. Moses Pretrick
Acting Secretary, FSM Department of Health & Social Affairs

III.G. Technical Assistance

Technical Assistance

FSM MCH program staff have taken advantage of training and technical assistance opportunities available through the MCH Bureau, AMCHP, and other national partners during annual conferences like the AMCHP Annual Conferences, Federal and State Partnership Meetings, HRSA and CDC Annual Epidemiology Conferences, MCHB Epidemiology Certificate Training Programs, Pacific Basic Technical Assistance Meetings, and other MCHB funded TA programs such as the MCH Program Budget Preparation and Expenditure Reporting Technical Assistance Training provided to FSM toward the end of 2019 facilitated by Ms. Cassie Lauver.

In light of our priorities and the activities we have identified for the upcoming year, and most especially with the ongoing process to decentralize health care services in the FSM States due to Covid-19, the FSM MCH program will submit TA requests to support our work on the following:

1. Development of a developmental screening tool for children 18 months and older;
2. Use of Telehealth: To support telehealth use in MCH public health systems in the FSM. The TA will be requested to expand and maintain the use of telehealth in Title V, CYSHCN, newborn screening.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - 2022 Title V Medicaid IAA MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 2020 Final FSM Data Matrix.pdf

Supporting Document #02 - Updated-2022 FSM MCH ACTION PLAN.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - FSM ORGANIZATIONAL CHART.PDF

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Federated States of Micronesia

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 519,806	
A. Preventive and Primary Care for Children	$ 159,580	(30.6%)
B. Children with Special Health Care Needs	$ 165,298	(31.7%)
C. Title V Administrative Costs	$ 47,302	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 372,180	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 115,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 816,225	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 931,225	
A. Your State's FY 1989 Maintenance of Effort Amount $ 440,000		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 1,451,031	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 653,300	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 2,104,331	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 368,300

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 569,064		$ 519,806	
A. Preventive and Primary Care for Children	$ 170,735	(30%)	$ 155,942	(30%)
B. Children with Special Health Care Needs	$ 170,785	(30%)	$ 161,140	(31%)
C. Title V Administrative Costs	$ 56,810	(10%)	$ 51,980	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 398,330		$ 369,062	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 440,000		$ 440,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 440,000		$ 440,000	
A. Your State's FY 1989 Maintenance of Effort Amount $ 440,000				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 1,009,064		$ 959,806	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 598,000		$ 585,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 1,607,064		$ 1,544,806	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 248,000	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 50,000	$ 50,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 300,000	$ 300,000

Form Notes for Form 2:

As an outcome of the Financial TA Training, FSM redefined and recalculated the state match and came up with a new MOE level higher than the level reported in 1989.

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: FSM Define the Children with Special Health Care Needs (CSHCN) as those Children between the ages of 0-21 years who are suspected of having one or more of the following conditions may be eligible for the CSHCN Assessment Clinic: Sensor (Visual Impairments, Hearing Impairments; Speech and Language impairments; Physical (Orthopedic) impairments; Neurologic impairments; Behavioral impairments; Specific Learning Disability; Multiple disabilities and other health impairments.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: FSM defines Administrative Cost as the actual salary and fringe benefits out of the total salary that the National MCH Program Manager used to run or coordinate the MCH Program at the national and state levels. This also includes the percent of funds, out of the total national travel funds that the national program management use to travel to the other FSM states to do program and financial monitoring..	
3.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The total budget request for FY-20 $569.064, has been adjusted to match with the grant award of $519,806. Therefore expenditures for 2020 is based on the approve amount of $519,806 awarded.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Federated States of Micronesia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 69,484	$ 60,971
2. Infants < 1 year	$ 18,883	$ 65,972
3. Children 1 through 21 Years	$ 159,580	$ 155,942
4. CSHCN	$ 165,298	$ 161,140
5. All Others	$ 59,259	$ 23,801
Federal Total of Individuals Served	$ 472,504	$ 467,826

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 102,000	$ 66,901
2. Infants < 1 year	$ 120,740	$ 65,874
3. Children 1 through 21 Years	$ 97,600	$ 88,776
4. CSHCN	$ 115,000	$ 115,000
5. All Others	$ 4,660	$ 67,946
Non-Federal Total of Individuals Served	$ 440,000	$ 404,497
Federal State MCH Block Grant Partnership Total	$ 912,504	$ 872,323

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

Field Note:
The total budget request for FY-20 $569.064, has been adjusted to match with the grant award of $519,806. Therefore expenditures for 2020 is based on the approve amount of $519,806 awarded.

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Federated States of Micronesia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 181,932	$ 217,835
3. Public Health Services and Systems	$ 337,874	$ 301,971
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 519,806	$ 519,806

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 440,000	$ 440,000
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 145,710	$ 182,000
B. Preventive and Primary Care Services for Children	$ 175,290	$ 143,000
C. Services for CSHCN	$ 119,000	$ 115,000
2. Enabling Services	$ 0	$ 0
3. Public Health Services and Systems	$ 0	$ 0
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 50,000
Physician/Office Services		$ 95,587
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 67,000
Dental Care (Does Not Include Orthodontic Services)		$ 63,752
Durable Medical Equipment and Supplies		$ 74,501
Laboratory Services		$ 89,160
Direct Services Line 4 Expended Total		$ 440,000
Non-Federal Total	$ 440,000	$ 440,000

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Federated States of Micronesia

Total Births by Occurrence: 1,895 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	1,706 (90.0%)	189	146	146 (100.0%)

Program Name(s)	
Critical Congenital Heart Disease	Hearing Loss

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Children with Special Health Care Needs- Rheumatic Disease	335	146	146	146
MCH Program Infant Anemia Screening	1,055	100	100	100
MCH Program Women Anemina screening	2,526	550	550	550
MCH Program Cervical Cancer screening	1,160	22	22	22

4. Long-Term Follow-Up

Infants who are born with confirmed cases are monitored by the doctors in the hospitals. The monitoring time and staying in the hospital depends on how severe the condition of the child is.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: All hospital and outside births	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: Vital statistics	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: New born hearing screen and rheumatic screening	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Federated States of Micronesia

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,905	0.0	0.0	0.0	100.0	0.0
2. Infants < 1 Year of Age	1,833	0.0	0.0	0.0	100.0	0.0
3. Children 1 through 21 Years of Age	24,811	0.0	0.0	0.0	100.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,856	0.0	0.0	0.0	100.0	0.0
4. Others	8,926	0.0	0.0	0.0	100.0	0.0
Total	37,475					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	1,981	Yes	1,981	99.0	1,961	1,905
2. Infants < 1 Year of Age	1,944	Yes	1,944	99.0	1,925	1,833
3. Children 1 through 21 Years of Age	42,337	Yes	42,337	90.0	38,103	24,811
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,454	Yes	3,454	90.0	3,109	1,856
4. Others	58,656	Yes	58,656	40.0	23,462	8,926

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: All pregnant women counts are from MCH program services data. Pregnant women who had received a preventive visit at the MCH program are free of charge, and medical insurance is not mandatory for them.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Services for Infants who had received services from the MCH program are free of charge.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Even if there are children with medical insurances, once they come and get services from the MCH program and the other public health programs, they are exempted to pay for any fees on their visits.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: CSHCN clients are free of charge at the MCH and other public health programs.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: These are Non pregnant women who seek MCH Services (cervical cancer screening, Domestic violence cases referred from OPD and other agencies) women who seek family planning services and other GYN services; and CSHCN clients who are aged out but are still seeking services from the MCH Program, such as Bicillin services; and husbands of pregnant women who are seeking counseling or STDs screening and treatment and de-worming medicines.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2020**
	Field Note: Based on the number of people reported in the total served, it was estimated that about 37% of the FSM population did receive services from the MCH program in 2020.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: The percent of pregnant women MCH program did cover in the reporting year is 96. About 4% of the pregnant women population which is mainly from the outer islands are not reached during the reporting year.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Based on services provided by MCH programs (EHDI program, Breastfeeding groups, anemia screening, etc), about 94% of infants are served by the MCH programs in the reporting year.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Most of the children in this age range did receive enabling services that the MCH program is providing, either in the communities or in the schools.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: With enabling and public health services and systems, the MCH program was able to reach the CSHCN population by 90% in the past year.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Since there were no direct strategies for the other group population (40%) in the MCH action plan, the enabling services in the communities are not prioritizing them as well.	

Data Alerts:

1.	Pregnant Women, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Federated States of Micronesia

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	1,883	0	0	0	0	0	1,883	0	0
Title V Served	1,855	0	0	0	0	0	1,855	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0
2. Total Infants in State	1,883	0	0	0	0	0	1,883	0	0
Title V Served	1,883	0	0	0	0	0	1,883	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Federated States of Micronesia

Toll-Free numbers are not available to all jurisdictions.

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number		
2. State MCH Toll-Free "Hotline" Name		
3. Name of Contact Person for State MCH "Hotline"		
4. Contact Person's Telephone Number		
5. Number of Calls Received on the State MCH "Hotline"		

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	None	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	under development	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	None	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Federated States of Micronesia

1. Title V Maternal and Child Health (MCH) Director	
Name	Dionisio Saimon
Title	MCH Program Manager
Address 1	PS 70
Address 2	
City/State/Zip	Pohnpei / FM / 96941
Telephone	6913202619
Extension	
Email	desaimon@fsmhealth.fm

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Dionisio Saimon
Title	MCH Program Manager
Address 1	PS 70
Address 2	
City/State/Zip	Pohnpei / FM / 96941
Telephone	6913202619
Extension	
Email	desaimon@fsmhealth.fm

3. State Family or Youth Leader (Optional)	
Name	Stanley S. Mickey
Title	Youth Leader
Address 1	PS 70
Address 2	
City/State/Zip	Pohnpei / FM / 96941
Telephone	6913202619
Extension	
Email	smickey@fsmhealth.fm

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Federated States of Micronesia

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to health services- Improve women's health through cervical cancer and anemia screening	Continued
2.	Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	Continued
3.	Improve child health through healthy weight through physical activity and nutrition promotion	New
4.	Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e drug, alcohol use) and poor outcome	Revised
5.	Provide care coordination training for parents/caregivers of Children with Special Health Care Needs	New
6.	Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits.	New
7.	Improve health promotion communication	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Access to health services- Improve women's health through cervical cancer and anemia screening	Continued
2.	Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	Continued
3.	Improve child health through healthy weight through physical activity and nutrition promotion	New
4.	Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor out	Revised
5.	Provide care coordination training for parents/caregivers of Children with Special Health Care Needs	New
6.	Improve screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits.	New
7.	Improve health promotion communication	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Federated States of Micronesia

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	30.6
Numerator	560
Denominator	1,833
Data Source	MCH Program and Vital Statistics
Data Source Year	2020

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

NOM 2 - Notes:

There was no (zero) maternal morbidity reported for this period.

Data Alerts:

1.	Data has not been entered for NOM 2. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2017	88.0		2	
2016	90.0		2	
2015	95.0		2	
2014	96.0		2	
2013	99.0		2	
2012	103.0		3	
2011	106.0		3	
2010	110.0		3	
2009	114.0		3	
2008	118.0		3	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	218.2
Numerator	4
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	11.0 %	1.8 %	2,262	20,558

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	7.2
Numerator	132
Denominator	1,833
Data Source	FSM Viral statistics
Data Source Year	2020

NOM 4 - Notes:

Actual data for 2020

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	23.1 %	2.9 %	4,739	20,558

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	3.6
Numerator	66
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	11.0
Numerator	201
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Federally available Data (FAD) for this measure is not available/reportable.

NOM 7 - Notes:

There was no data for this measure due to no one is receiving services or being categorized under this measure.

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	38.2
Numerator	70
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	24.5		63	
2018	25.6		65	
2017	26.4		67	
2016	27.3		69	
2015	28.0		70	
2014	28.8		72	
2013	29.6		74	
2012	30.5		76	
2011	31.4		79	
2010	32.3		81	
2009	33.3		85	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	19.1
Numerator	35
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 9.1 - Notes:

Definite FSM infant mortality in 2020.

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	15.9		41	
2018	16.0		41	
2017	16.5		42	
2016	17.1		43	
2015	17.7		45	
2014	18.4		46	
2013	19.0		47	
2012	19.6		49	
2011	19.9		50	
2010	20.4		51	
2009	20.9		53	

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	13.1
Numerator	24
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	6.0
Numerator	11
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	545.6
Numerator	10
Denominator	1,833
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Federally available Data (FAD) for this measure is not available/reportable.

NOM 9.5 - Notes:

Data on this measure has not been collected yet. FSM will start to collect data on this measure in 2022.

Data Alerts:

1.	Data has not been entered for NOM 9.5. This outcome measure is linked to the selected NPM 4,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Federally available Data (FAD) for this measure is not available/reportable.

NOM 10 - Notes:

FSM did not collect data on this measure. FSM will include this measure in their collection and reporting tools starting in 2022.

Data Alerts:

1.	Data has not been entered for NOM 10. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Federally available Data (FAD) for this measure is not available/reportable.

NOM 11 - Notes:

FSM does not have the expertise in this area, so data was difficult to obtain for this measure.

Data Alerts:

1.	Data has not been entered for NOM 11. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 12 - 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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	18.2 %	3.7 %	3,433	18,899

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	7.5
Numerator	2,998
Denominator	39,882
Data Source	Dental clinic and Oral Health programs
Data Source Year	2020

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	93.2
Numerator	19
Denominator	20,396
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	17.7
Numerator	4
Denominator	22,576
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	8.9
Numerator	1
Denominator	11,214
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	17.8
Numerator	2
Denominator	11,214
Data Source	FSM Vital Statistics
Data Source Year	2020

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.8 %	1.9 %	1,607	20,558

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	4.4
Numerator	1,856
Denominator	42,272
Data Source	CSHCN PROGRAM and CENSUS
Data Source Year	2020

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 % ϟ	0 ϟ	0 ϟ	1,607 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	80.8
Numerator	1,503
Denominator	1,860
Data Source	CSHCN PROGRAM ad Census
Data Source Year	2020

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0.2 % ϟ	0.2 % ϟ	32 ϟ	17,039 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	0.1
Numerator	21
Denominator	35,184
Data Source	CSHCN PROGRAM
Data Source Year	2020

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0.5 % ϟ	0.4 % ϟ	84 ϟ	17,039 ϟ

Legends:

ϟ Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	0.1
Numerator	23
Denominator	35,184
Data Source	CSHCN PROGRAM
Data Source Year	2020

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	0 %	0	0	490

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	88.5
Numerator	23
Denominator	26
Data Source	CSHCN PROGRAM and BEHAVIORAL HEALTH PROGRAM
Data Source Year	2020

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	75.8 %	2.8 %	15,580	20,558

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	47.3
Numerator	20,004
Denominator	42,272
Data Source	MCH PROGRAM
Data Source Year	2020

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: MCH Jurisdictional Survey (MCH-JS) - Age 10-17

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	27.5 %	5.4 %	2,632	9,560

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	2.9
Numerator	507
Denominator	17,292
Data Source	MCH PROGRAM
Data Source Year	2020

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	61.4 %	4.2 %	12,618	20,558

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	65.8
Numerator	27,823
Denominator	42,272
Data Source	FSM MiCare Health Insurance
Data Source Year	2020

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	68.4
Numerator	3,568
Denominator	5,213
Data Source	FSM Immunization Program
Data Source Year	2020

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	50.2
Numerator	19,722
Denominator	39,324
Data Source	FSM Immunization Program
Data Source Year	2020

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	33.4
Numerator	3,931
Denominator	11,775
Data Source	FSM Immunization program
Data Source Year	2020

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	27.7
Numerator	4,119
Denominator	14,867
Data Source	FSM Immunization program
Data Source Year	2020

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Federally available Data (FAD) for this measure is not available/reportable.

NOM 22.5 - Notes:

FSM does not have the meningococcal conjugate vaccine.

Data Alerts:

1.	Data has not been entered for NOM 22.5. This outcome measure is linked to the selected NPM 10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018	13.2			
2017	13.9			
2016	14.9			
2015	15.8			
2014	16.7			
2013	17.6			
2012	18.6			
2011	19.9			
2010	21.3			
2009	22.7			

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	38.7
Numerator	177
Denominator	4,569
Data Source	MCH Program
Data Source Year	2020

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2020
Annual Indicator	0.0
Numerator	2
Denominator	4,568
Data Source	Pohnpei Behavioral Health and Wellness program
Data Source Year	2020

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: MCH Jurisdictional Survey (MCH-JS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	8.5 %	2.4 %	1,756	20,558

Legends:

Indicator has a confidence interval width >20% or >1.2 times the estimate and should be interpreted with caution

State Provided Data	
	2020
Annual Indicator	13.4
Numerator	5,152
Denominator	38,497
Data Source	MCH Program
Data Source Year	2020

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Federated States of Micronesia

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective		85
Annual Indicator	57.8	57.8
Numerator	9,102	9,102
Denominator	15,758	15,758
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20	30	78	80	85
Annual Indicator	26	76.3	73.8	57.8	43.9
Numerator	1,320	9,582	7,074	9,102	3,046
Denominator	5,080	12,556	9,589	15,758	6,940
Data Source	MCH program	MCH program	MCH Program	MCH Program	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.0	53.0	55.0	60.0	65.0	75.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: There are no population-based data for this NPM. However, FSM did collect data on women (21-44 yrs. old) who had received their pap-smear/VIA in the past year as a proxy to NPM 1.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: There is no survey that will show a population-based data on this measure. Data was captured from different preventive services such as (anemia screening, Pap/VIA screening, dental screening & etc).	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: FSM does not have a population-based survey to satisfy this measure. Data was captured from different preventive services such as (anemia screening, Pap/VIA screening, dental screening & etc).	

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	0	0.3
Numerator	0	5
Denominator	100	1,833
Data Source	N/A	Vital Statistics
Data Source Year	N/A	2020
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	0.2	0.2	0.1	0.0	0.0	0.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This is a new measure and will be reported on beginning in 2021.

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CHILD		
	2019	**2020**
Annual Objective		
Annual Indicator	41.2	41.2
Numerator	2,724	2,724
Denominator	6,612	6,612
Data Source	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	42.0	43.0	44.0	45.0	46.0	50.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	40	45
Annual Indicator	23.2	23.2
Numerator	1,680	1,680
Denominator	7,251	7,251
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			35	40	45
Annual Indicator	0	0	0	23.2	
Numerator	0	0	0	1,680	
Denominator	100	100	100	7,251	
Data Source	-- State --	-- State --	-- State --	State	
Data Source Year	-- State	-- State	-- State	State	
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note:	There are no FSM population-based data for this NPM.
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note:	The preventive medical visit data was not collected in 2017. FSM did collect an alternate indicator for this NPM - Increase education awareness on Reproductive health, Substance abuse and Physical healthh nutrition in 25% schools. The numerator is # of schools received educational awareness on healthy lifestyle, and denominator is # of Schools (7-12 grades) in State.
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note:	FSM discontinued to report on this NPM due to lack of data. Moreover, the proxy for this NPM is ESM 10.2

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	10.4	10.4
Numerator	167	167
Denominator	1,607	1,607
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	2.0	3.0	4.0	5.0	6.0	10.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Federated States of Micronesia

2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	85	90
Annual Indicator	81.9	81.9
Numerator	5,485	5,485
Denominator	6,694	6,694
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	63	80	80	85	90
Annual Indicator	0	0	0		
Numerator	0	0	0		
Denominator	100	100	100		
Data Source	-- State --	-- State --	-- State --		
Data Source Year	-- State	-- State	-- State		
Provisional or Final ?	Provisional	Provisional	Provisional		

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: No data collected for this measure in 2016.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This measure is not selected for 2017 reporting.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Measure not selected for 2018 reporting.	

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	70	73	75	78	80
Annual Indicator	69.7	59.9	70.7		
Numerator	1,359	1,173	1,336		
Denominator	1,950	1,958	1,890		
Data Source	MCH	MCH program	MCH program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Provisional	Provisional	Provisional		

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS) - CSHCN		
	2019	**2020**
Annual Objective	10	15
Annual Indicator	10.4	10.4
Numerator	70	70
Denominator	676	676
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			8	10	15
Annual Indicator	2.4	5.5	1.4		
Numerator	46	86	21		
Denominator	1,910	1,551	1,462		
Data Source	CSHCN program	CSHCN program	CSHCN program		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Provisional	Provisional	Provisional		

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: FSM use percentage of CSHCN youths employed as a proxy for this NPM.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: This indicator was tracked based on questions asked during services for CSHCN families whom their kids received transitional service from the CSHCN programs.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This indicator was tracked based on the proxy question asked during CSHCN services on transitional service from the CSHCN programs. In 2018, not many clients were able to attend a rehabilitation service.	

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: MCH Jurisdictional Survey (MCH-JS)		
	2019	**2020**
Annual Objective	22	27
Annual Indicator	10.6	10.6
Numerator	1,998	1,998
Denominator	18,899	18,899
Data Source	MCH-JS	MCH-JS
Data Source Year	2019	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			17	22	27
Annual Indicator	9.4	11.9	27		
Numerator	1,861	2,320	7,555		
Denominator	19,766	19,543	28,003		
Data Source	Dental program and Census	Dental Health and Census	Dental program and Census		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Provisional	Provisional	Provisional		

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data was collected for NPM 13B (children ages 1-9 yrs. old)	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Oral health for children K5- 3rd graders receiving dental awareness and dental services (varnish and sealants) is a proxy for this NPM.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Dental for children 1 to 5 years old and children in K5 to 3rd graders receiving dental awareness and dental services (varnish and sealants) is a proxy for this NPM.	

Form 10
State Performance Measures (SPMs)

State: Federated States of Micronesia

SPM 1 - Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	7.0	12.0	15.0	20.0	30.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of women (15-44 years old) screened for anemia for the past year

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		13	75	22	27
Annual Indicator	15.1	69.5	19.4	14.6	10.8
Numerator	615	5,272	4,384	384	2,526
Denominator	4,064	7,584	22,610	2,629	23,492
Data Source	MCH program	MCH program	MCH program and Census	MCH program	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	50.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This measure was already tracked in the ESMs; therefore, this SPM will be changed in 2017/2019 application to the percent of pregnant women aged 15 through 44 years diagnosed with Syphilis who are treated with penicillin.

SPM 3 - Percent of pregnant women who are screened for gestational diabetes by 24-28weeks.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	30.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	10.0	20.0	30.0	40.0	50.0

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of parents/caregivers receiving training on specialty care for children with special health care needs (CSHCN)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - Percent of infants screened for hearing

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		83	76	80	85
Annual Indicator	79.1	73	79.9	79	85.1
Numerator	1,599	1,512	1,589	1,552	1,560
Denominator	2,021	2,072	1,989	1,964	1,833
Data Source	EHDI program and Vital stats	EHDI program and Vital stats	EHDI program and Vital stats	EHDI program	EHDI program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 6 - Prevalence rate of 0-9 years old hospitalized for nonfatal injury/100,000

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			500	400
Annual Indicator			392	547.8
Numerator			175	128
Denominator			44,643	23,368
Data Source			FSM MCH Data Matrix	Vital Statistics
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 7 - Percentage of pregnant women with a first-trimester prenatal visit

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			50	60
Annual Indicator			30.6	30.6
Numerator			579	560
Denominator			1,890	1,833
Data Source			MCH program	MCH program
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 8 - Percent of women 21-65 years old who have had VIA/PAP screening performed within the past year

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			20
Annual Indicator			19
Numerator			1,160
Denominator			6,102
Data Source			MCH Program
Data Source Year			2020
Provisional or Final ?			Provisional

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Federated States of Micronesia

ESM 1.1 - Percent of women, ages 18 through 44, attending community outreach events on preventive medical visits in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective						

Field Level Notes for Form 10 ESMs:

None

ESM 3.1 - Percent of low birth weight infants born in the hospital

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	1.0	0.7	0.5	0.2	0.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Percent of children ages 6 – 11 years who are doing physical activities in schools at least 60 minutes daily before, during, and after the school day

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	70.0	80.0	85.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of adolescents ages 12 through 17 attending educational awareness on preventive medical visits in the schools

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			35	38
Annual Indicator			61.5	78.3
Numerator			99	137
Denominator			161	175
Data Source			MCH program and Education	MCH program and Education
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	40.0	45.0	50.0	60.0		

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of CSHCN providers and parents/caregivers received components of the medical home training

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective						

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - # of community-based education events each year

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		28	30	32	35
Annual Indicator	26	21.6	25.3	0	25
Numerator	1,320	1,637	5,728	0	1
Denominator	5,080	7,584	22,610	100	4
Data Source	MCH program	MCH program	MCH program and Census	NA	MCH Program
Data Source Year	2016	2017	2018	NA	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Screenings of Pap/VIA and Anemia were merged for this indicator and will start to be tracked from 2019 and on.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data not collected during reporting year.	

2016-2020: ESM 4.2 - Percent of six months old exclusively breastfed.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		73	65	75	80
Annual Indicator	69.7	59.4	70.7	76.1	66.7
Numerator	1,359	1,155	1,336	1,511	1,237
Denominator	1,950	1,944	1,890	1,986	1,855
Data Source	MCH program and Birth Certificate	MCH program and Birth Certificate	MCH program and Birth Certificate	MCH Program and Vital Statistics	MCH Program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	15	30	35
Annual Indicator	2.4	1.3	0	17.8	80.8
Numerator	46	18	0	173	1,503
Denominator	1,910	1,414	100	972	1,860
Data Source	CSHCN program	CSHCN program	CSHCN program	CSHCN program	CSHCN program
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Kosrae State did not have any transitioning program for their CSHCN population.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Data was reported on old indicator: Percentage of CSHCN youths employed. FSM will start to report on this indicator starting in 2019.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This measure is new and will be track starting this reporting year.	

2016-2020: ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		15	50	30	40
Annual Indicator	9.4	46.9	0	54.1	78.3
Numerator	1,861	4,701	0	99	137
Denominator	19,766	10,020	100	183	175
Data Source	Dental program and Census	Dental program and Census	Dental program and Census	Dental program and Education	Dental program and Education
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
This measure will be tracked starting this reporting year.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Federated States of Micronesia

SPM 1 - Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the number of women with cervical cancer through early screening.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women ages 21-65 years old who had Pap or VIA screening in the past year **Denominator:** Total number of women ages 21-65 years old in the State
Healthy People 2030 Objective:	Increase the proportion of females who get screened for cervical cancer
Data Sources and Data Issues:	FSM MCH and Cancer Programs
Significance:	Healthy People 2030 focuses on promoting evidence-based cancer screening and prevention strategies — and on improving care and survivorship for people with cancer. The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States

SPM 2 - Percent of women (15-44 years old) screened for anemia for the past year
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To screen all women for Anemia at the public health, hospital, dispensaries, schools and CHC.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of women (15-44 years old) screen for Anemia. **Denominator:** Number of women (15-44 years old) in the state
Data Sources and Data Issues:	Public Health Records
Significance:	Anemia is a a serious health problem for pregnant women in the FSM. It is better to track and treat anemia before a woman gets pregnant.FSM decides to detect and treat anemia early before pregnancy to avoid complication of anemia during pregnancy.

SPM 3 - Percent of pregnant women who are screened for gestational diabetes by 24-28weeks.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce the rate of fetal deaths at 20 or more weeks of gestation.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of pregnant women at 20 to 24 weeks who are screened for gestational diabetes **Denominator:** The total number of pregnant women during the reporting year.
Healthy People 2030 Objective:	Reduce the rate of fetal deaths at 20 or more weeks of gestation.
Data Sources and Data Issues:	MCH Programs
Significance:	Some suspected causes of fetal death include infections, chronic diseases like diabetes, and substance use during pregnancy. Although studies to better understand what causes fetal death are needed, there are strategies that can help reduce fetal deaths — like making sure pregnant women who have pregnancy-related complications or substance use disorders get the right treatment.

SPM 4 - Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors, and reducing risk behavior and poor outcomes.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 12-17 years old attended education on adolescent's health during the past year **Denominator:** Total number fo 12-17 years old in the State
Healthy People 2030 Objective:	Increase the proportion of adolescents who had a preventive health care visit in the past year
Data Sources and Data Issues:	FSM MCH programs and Dept. of Education
Significance:	During preventive health care visits, adolescents get important screenings, health counseling, and interventions. Preventive visits are especially important for this age group because behaviors that can affect health often start in adolescence.

SPM 5 - Percent of parents/caregivers receiving training on specialty care for children with special health care needs (CSHCN)
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Improve specialize providers in care coordination among children with special health care needs
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of parents/caregivers receiving trainings on care coordination for CSHCN **Denominator:** Total number of parents/caregivers during the reporting year
Healthy People 2030 Objective:	Improve care coordination through trainings in children with special health care providers
Data Sources and Data Issues:	CSHCN and Other Public Health Programs
Significance:	Improve care coordination among Children with special health care needs

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 4 - Percent of infants screened for hearing
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase percent of newborns who had hearing screening</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children screened for hearing</td></tr>
<tr><td>Denominator:</td><td>Number of occurent births during the reporting year</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FSM HER-FamilyTrac System; Birth records</td></tr>
<tr><td>Significance:</td><td>Hearing health is important as it also determines a child's future educational attainment.</td></tr>
</table>

2016-2020: SPM 6 - Prevalence rate of 0-9 years old hospitalized for nonfatal injury/100,000 Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Reduce rate of hospitalization for non-fatal injury
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of 0-9 years old injured **Denominator:** Number of 0-9 years old in the state
Data Sources and Data Issues:	Hospital and Public Safety
Significance:	According to WHO, Injuries–resulting from traffic collisions, drowning, poisoning, falls or burns - and violence - from assault , self-inflicted violence or acts of war–kill more than five million people worldwide annually and cause harm to millions more. They account for 9% of global mortality, and are a threat to health in every country of the world. For every death, it is estimated that there are dozens of hospitalizations, hundreds of emergency department visits and thousands of doctors' appointments

2016-2020: SPM 7 - Percentage of pregnant women with a first-trimester prenatal visit
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To improve perinatal outcomes during the early prenatal care visit
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of live births with reported first prenatal visit during the first trimester (before 13 weeks = gestation) in the calendar year.</td></tr><tr><td>**Denominator:**</td><td>Total number of live births in the State in the calendar year.</td></tr></table>
Healthy People 2020 Objective:	Reduce the rate of fetal deaths
Data Sources and Data Issues:	FSM MCH programs
Significance:	Visits during the first trimester improve the development of the baby and the pregnancy.

2016-2020: SPM 8 - Percent of women 21-65 years old who have had VIA/PAP screening performed within the past year
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To screen all women for cervical cancer in Public health, Hospital, dispensaries, CHC and schools
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total number of women ages 21-65 years old who have had cervical cancer screening **Denominator:** Total number of women ages 21-65 years old in the State
Data Sources and Data Issues:	FSM MCH and Cancer programs
Significance:	Cervical cancer is one of the highest mortality rates among women in the FSM.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Federated States of Micronesia

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Federated States of Micronesia

ESM 1.1 - Percent of women, ages 18 through 44, attending community outreach events on preventive medical visits in the past year
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Improve women's health through community outreach events on women preventive medical visits
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women, ages 18 through 44 attending community outreach events on preventive medical visits **Denominator:** Total number of women, ages 18 to 44 in the reporting year
Data Sources and Data Issues:	FSM population-based data, FSM Census
Significance:	Health promotion and education are identified as leading barriers to accessing health services. It is believed and hoped that better and increased educational events will lead to more women attending preventive care especially cervical cancer and anemia screening.

ESM 3.1 - Percent of low birth weight infants born in the hospital
NPM 3 – Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active
Goal:	Improve pregnant women who receive prenatal care beginning in the first trimester
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of low birth weights in the hospital **Denominator:** Total number of livebirths
Data Sources and Data Issues:	Public health and CHC
Evidence-based/informed strategy:	Increase access and visibility
Significance:	Improve perinatal outcomes

ESM 8.1.1 - Percent of children ages 6 – 11 years who are doing physical activities in schools at least 60 minutes daily before, during, and after the school day
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>Children 6 through 11</td></tr>
<tr><td>Goal:</td><td>Improve child health through healthy weight with physical activity and nutrition promotion</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children ages 6 – 11 years who are doing physical activities in the schools at least 60 minutes daily</td></tr>
<tr><td>Denominator:</td><td>Total number of children ages 6 – 11 in the schools</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Public Health Outreach Data, Dept. of Education records and data</td></tr>
<tr><td>Significance:</td><td>Children attending schools with PE periods and after-school programs have healthy weights and physically healthy.</td></tr>
</table>

ESM 10.1 - Percent of adolescents ages 12 through 17 attending educational awareness on preventive medical visits in the schools
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase educational awareness on healthy behaviors and risk behaviors to adolescents ages 12-17 years old in the schools.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adolescents ages 12 through 17 attending educational awareness on preventive medical visits **Denominator:** Total number of adolescents ages 12 through 17 in the schools
Data Sources and Data Issues:	MCH and Department of Education
Significance:	Women who become pregnant during their teens are at increased risk for medical complications, such as premature labor, and social consequences.

ESM 11.1 - Percent of CSHCN providers and parents/caregivers received components of the medical home training
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN and non-CSHCN
Goal:	Increase the percentage of identified CSHCN provided with a medical home
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN providers and parents/caregivers received components of the medical home training **Denominator:** The total number of CHSCN providers and parents/caregivers during the reporting year.
Data Sources and Data Issues:	CSHCN Registry
Significance:	Training and care coordination leads to a well functioning system of care for CSHCN and their parents and care givers.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - # of community-based education events each year
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase awareness workshops to women ages 15-65 in the communities on cervical cancer and anemia screening.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening **Denominator:** Total number of women (15-65 years old) in the state
Data Sources and Data Issues:	Public Health Data, Census
Significance:	Cervical cancer is one of the leading causes of death for women in the FSM. The MCH program wishes to prioritize cervical and anemia screening by increasing awareness workshops on Pap smear and VIA screening during a women's preventive visit so cervical cancer can be detected early and treated.

2016-2020: ESM 4.2 - Percent of six months old exclusively breastfed.
2016-2020: NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase percent of infants who are ever breastfed and breastfed up to six months
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of babies having 6 months old well baby visit in MCH clinics in 2019 noted to be exclusively breastfed</td></tr><tr><td>**Denominator:**</td><td>Number of babies having 6 months old well baby visit in MCH clinics in 2019</td></tr></table>
Data Sources and Data Issues:	MCH Program Data and Vital Statistics
Significance:	Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child’s nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post-natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

2016-2020: ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.
2016-2020: NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Collaborate with Department of Education (SPED), IAC Department of Health and other NGOs to strenghten the services for CSHCN youths in each state.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CSHCN youth registered for non-medical related services **Denominator:** Total number of CSHCN youth in the registry
Data Sources and Data Issues:	CSHCN Data
Significance:	In the FSM, the CSHCN Inter-agency Council has member representative from the private sector, people who run major businesses and hardware stores in the country. By involving business representatives on the council, it is our hope that the business community will learn more about the children and youths with special health care needs and the transition program and therefore provide them with employment opportunities.

2016-2020: ESM 13.2.1 - Percentage of elementary schools visited by dental program
2016-2020: NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of schools visited to educate and provide preventive measures (varnish & sealant).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of elementary schools visited by dental program **Denominator:** Number of elementary schools
Data Sources and Data Issues:	Dental Health data and School record
Significance:	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.

Form 11
Other State Data

State: Federated States of Micronesia

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Federated States of Micronesia

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	3		
2) Vital Records Death	Yes	No	Annually	12	Yes	
3) Medicaid	No	No	Never	NA	No	
4) WIC	No	No	Never	NA	No	
5) Newborn Bloodspot Screening	No	No	Never	NA	No	
6) Newborn Hearing Screening	Yes	Yes	Daily	3	Yes	
7) Hospital Discharge	Yes	Yes	More often than monthly	1	Yes	
8) PRAMS or PRAMS-like	No	No	Never	NA	No	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) FSM MCH Data Matrix	Yes	Yes	Monthly	3	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	**3) Medicaid**
	Field Note: FSM does not have Medicaid
Data Source Name:	**4) WIC**
	Field Note: FSM does not have WIC.
Data Source Name:	**5) Newborn Bloodspot Screening**
	Field Note: FSM does not provide bloodspot screening.

Other Data Source(s) (Optional) Field Notes: