Maternal and Child Health Services Title V Block Grant

Federated States of Micronesia

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS
FSM National Government
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Palikir, Pohnpei 96941
Federated States of Micronesia
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Office of the Secretary

July 28, 2023

HRSA Grants Application Center
Attn: MCH Block Grant
901 Russel Avenue, Suite 450
Gaithersburg, MD 20879

Dear Sir or Madam:

I am pleased to submit the continuing application for the Title V MCH Block Grant for FY-2024 from the Federated States of Micronesia. We certainly hope that this application meets your submission requirements. Please let us know if further information is needed.

You may contact Mr. Dionisio Saimon directly at desaimon@fsmhealth.fm for any inquiry.

Once again, thank you for this partnership.

Sincerely,

Mr. Moses Pretrick
Acting Secretary, FSM Department of H&SA

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: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

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

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 104,832 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.

The FSM MCH program convened an annual meeting on site at the Department of Health and Social Affairs office to review the progress of the 2022 work plan and plan for the 2024 grant application. The meeting was in-person represented by the FSM State MCH coordinators, data clerks and CHSCN coordinators. This was the first MCH annual meeting held since the outbreak of the COVID 19 pandemic.

The tools used to measure the progress of the MCH program was based on the State's progress reports and program monitoring visits to the States. Although there were slight improvements in alignment of NPMs, SPMs, and ESMs in this year's reporting period there are still existing challenges around measuring the stated indicators. Some relevant examples are listed below:

WOMAN AND 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.

All the FSM States experienced setbacks and challenges with program implementation as a result of the COVID 19 pandemic responses. All public health employees including MCH staff were repositioned to man and support the COVID 19 response plans both at the hospital settings and during repatriation flights into the FSM. In the State of Yap, health care workers went on strike and health care services shifted to the Independent Community Health Centers (CHC) to supplement the impacts of public health programs.

PERINATAL AND INFANT HEALTH

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.

Breastfeeding education and awareness continue to be a priority for mothers since childcare education is lacking in the FSM. New mothers rely on families for childcare rearing and for healthy feeding practices. However, the MCH and public health education and awareness campaigns and services were interrupted by the COVID 19 pandemic and the Government's response to keep the virus out of the country. MCH programs including other public health programs were repositioned and mandated to support the Government's COVID 19 response measures to minimize its negative impacts.

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.

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.

Currently developmental screenings are only completed on the MCH population but not the population at large. Current screening tools are developed up until age 18 months and 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.

Public Health awareness in the schools were limited due to the Covid 19 response plan in 2022 that restricted social gathering and social distancing and schools were close down during the pandemic.

ADOLESCENT HEALTH

In 2022, Public Health awareness in the schools were limited due to the Covid 19 response plan that restricted social gathering and social distancing and schools were closed during the pandemic. MCH program encountered shortage of staff to implement health awareness activities at the schools and communities due to most program staff were pull to do covid-19 activities. And despite the CO VID 19 restrictions, the MCH program continued to partner with other Public Health programs (PREP,FP , HIV.STIs) and other government agencies (AG Office, DOE, Public safety) in

doing awareness on Teen pregnancy, STIs, Drugs and alcohol use and domestic violence and with the inclusion of the importance of early medical check-up since its staff were part of the National and State Task Forces.

CSHCN

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 Program tracks percent of children identified with a special health care need that are part of the CSHCN Program especially among hard of hearing clients. 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. However, specialty care and specialists in country continues to be a major problem in all FSM States.

Revisions to the existing ESM and strategies continued with delays in the plan implementation as an effect of pandemic conditions. Key highlights are provided by domain and priority health issues. Evidenced-Based Informed Strategic Measures for the selected Child NPM and Strategies was modified and the remaining SPMs will be tract in 2024.

The FSM revisited the seven priorities and strategies based on the 2022 Summary Review:

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

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

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 received early and adequate prenatal care services beginning during the first trimester including gestational diabetes screening 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	SPM #5 - Percent of parents/caregivers receiving and completed training in Care Coordination of services for children with special health care needs (CSHCN).

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 Complement State-Supported MCH Efforts

How Federal Title V Funds Support State MCH Efforts

As usual the MCH Block Grant Fund supports the overall MCH efforts in the Federated States of Micronesia (FSM). Primarily, the Block Grant fund supports 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, evaluation and screening. Additionally, funds are used to support workforce development towards building capacity among MCHB staff and partners who impact FSM's Title V Priorities.

III.A.3. MCH Success Story

Kosrae Cancer Survivor Group SUCCES STORY

The Kosrae Cancer Survivors Organization is a sub-group with the Kosrae Comprehensive Cancer Coalition formulated during the year 2006 or thereabout and was tasks with the important responsibility to provide health education about cancer and its effects in the people of the State of Kosrae.

The group was very active at the beginning but became a bit inactive when the Program Manager who organized this group moved on. In 2020, the Kosrae Cancer Survivor Organizations was reactivated. When this group get back together, there were about thirty members. Some died and some migrated to seek medical support outside of the FSM.

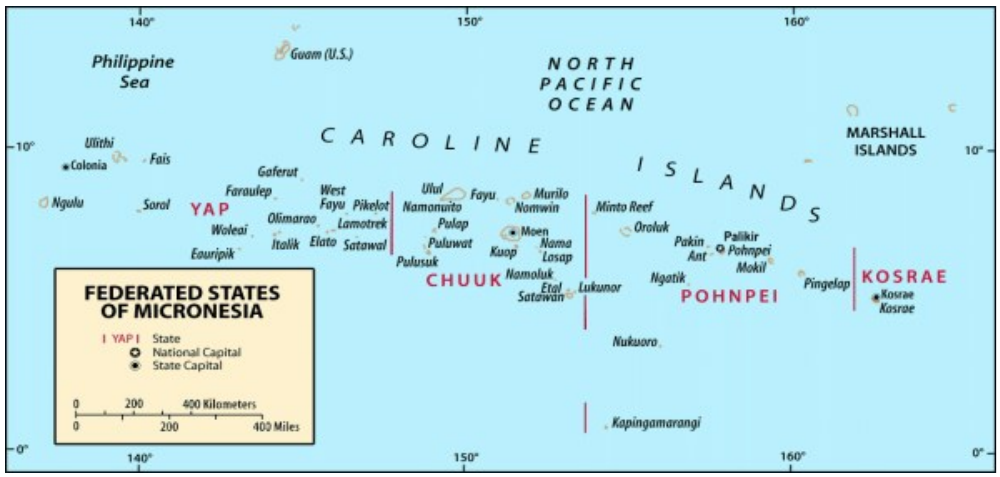
This group supported and contributed a lot to the MCH program. Their main goal was to convince more women to come for early breast and cervical cancer screening. They were recruiting and advocating for early screenings by sharing their own journeys and stories. They also did outreach activities by stressing the importance of early screening; as a result, more women became aware and wanted to be screened early.

III.B. Overview of the State

II.A. OVERVIEW OF THE STATE

Geography & Demography

The FSM is an island nation consisting of approximately 607 islands in the Western Pacific Ocean. Although the total area encompassing the FSM is very expansive, the total land area is only 271 square miles with an additional 2,776 square miles of lagoon area. The 607 islands vary from large, high mountainous islands of volcanic origin to small flat uninhabited atolls. The FSM consists of four geographically and politically separate states: Chuuk, Kosrae, Pohnpei, and Yap.



https://promusa.org

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, the islands of the Chuuk Lagoon, and the islands of the outlying atolls - a total of approximately 290 islands in all. 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 and is surrounded by 140 miles of coral reef. Because of the vast expanse of water between islands, travel within the State of Chuuk 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 program and family planning services, to the population of Chuuk is made difficult by the lack of transportation and communication with widely dispersed, small clusters of the populations on outer and lagoon islands.

The State of Kosrae is the only single-island state in the FSM and the furthest southeastern point of the four FSM states. 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 of easy driving. The state is divided into the four municipalities of: Lelu, Malem, Utwe, and Tafunsak. However, 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.

The State of Pohnpei consists of the main island of Pohnpei and eight smaller outer islands. The island of Pohnpei, the largest island in the FSM, is approximately 13 miles long with a land mass of 129 square miles. It is subdivided

into five municipalities of Madolenihmw, U, Nett, Sokehs, Kitti, and the town of Kolonia where the majority of the government buildings and offices, and the Pohnpei State Hospital are located. Of the outer islands of Pohnpei, to the south lies Kapingamarangi (410miles 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 program. The outer islands are the most difficult to reach because of the infrequent and undependable ships to bring supplies and health personnel to deliver goods and services.

The State of Yap lies in the western most part of the Federated States of Micronesia. Yap proper is the primary area in Yap state and is a cluster of four islands (Yap, Gagil-Tomil, Maap, and Rumung) connected by roads, waterways, and channels. 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 program services because of unpaved dirt roads. The outer islands are also difficult to reach because of infrequent ships to bring supplies and health personnel to deliver goods and services.

Population distribution

Based on the 2021 Census projection, the total population of the FSM is 104,832 residents. Kosrae, with the smallest population, has 6,744 residents (6.4%); then Yap with 11,597 persons (11%); then Pohnpei state with 36,896 (35.2%). Chuuk has the largest population with 49,595 residents (47.3%). There are 23,533 women of child-bearing years of 15-44, which is 22.4% of the total population. The population structure continues to show that 49,627 (47.3%) of the residents are under 20 years and children under five-years comprise 12,306 or 11.7%.

About 35.7% of the total population were aged 0-14 years, 58.7% were aged 15-59 years, and 5.6% were aged 60 years and above. The median age is 21.5 years, an increase of about 3 years since 2000, indicating the FSM population is ageing. The sex ratio 102.7, indicating the FSM population is dominantly male.

Age structures of all the states, including many of the outer islands, are undergoing dramatic changes, associated with international and rural-urban migration combined with an on- going transition to lower rates of fertility and mortality. Overall, the population is contracting in the 0-9 age group while increasing in the 10-19 age group as a result of previous fertility levels. In Yap and Kosrae the 20-44 age group shows the effects of age-selective out-migration.

Dramatic age-structure changes are also evident in the outer islands of Pohnpei, Chuuk and some municipalities of Kosrae. Such age distributions have major consequences for local production as well as social welfare and health care, particularly of older women and children who are often "left behind".

System of Care Population Served

The 2020 FSM population projection estimates showed that there were 22,693 women of reproductive age (defined as women 15-44 years old). It was reported that about 1,700 of the women who are pregnant had received direct

services from the MCH programs in 2021.

2020 FSM Census POPULATION ESTIMATES			
Sex/Age	**Total**	**Male**	**Female**
Total	**46,883**	**24,190**	**22,693**
15 to 19	11,326	5,731	2,893
20 to 24	10,840	5,577	2,564
25 to 29	8,658	4,695	2,321
30 to 34	6,012	3,262	5,410
35 to 39	5,110	2,507	5,248
40 to 44	4,804	2,417	4,258

Sources: FSM Census Population Projection

The number of infants (less than one year old) in the 2020 FSM population projection was 2,140. The 2020 population estimates show that there were 44,215 of children ages (0-19 years old) including the CSHCN population. About one third of this age group was served by the MCH programs services.

Government

The 23rd Congress of the Federated States of Micronesia (FSM) began its first regular session on May 11, 2023 and on the same day elected the new president and vice president of the FSM. The new president is Wesley W. Simina from the state of Chuuk and also the 10th president of the Federated States of Micronesia. Aren B. Palik from the island of Kosrae is re-elected as the vice-president for the nation.

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. Although there is the FSM National Constitution that 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.

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.

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. 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.

Economy

The FSM's economy remains dominated by the public sector. Over 50% of the labor force is employed in public administration or state-owned enterprises and the government sector generates 40% of gross domestic product (GDP). Despite the combined efforts of the FSM Government, the U.S. Government and various development partners, little new private sector investment has occurred.

According to the latest Household and Income Expenditure Survey (HIES) in 2013/14, the FSM per capita income was $2,112. The average household size was 6.2 persons. The average household income for the FSM household was $16,950. Pohnpei had a much higher household income at $22,293. Chuuk has the lowest household income at $11,398. Kosrae and Yap household income lies in the middle at $18,461 and $17,768 respectively. The median individual and household incomes for Yap, Pohnpei and Chuuk main islands were higher than the median incomes of the outer islands creating even further disparities. Thus, the need for MCH services among the poor remains high.

Insurance status

The majority of the FSM population does not have health insurance. Health care is provided at a minimal cost by the government. MCH funding for services and Family Planning commodities are provided with no cost given they have been donated by US HHS & UNFPA, who prohibit their resale.

In the FSM are designed and delivered at the State level. At the State level, the Department 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 all of the acute inpatient and outpatient medical services for the residents of the state. Each State now has a 330-funded Community Health Center. There are very few private health care providers in FSM, but Pohnpei State has several that add extra service delivery for the population in Pohnpei.

Organizational Structure

There are two levels of government in the FSM, the National Government level and the State Government level. The FSM is self-governing with locally elected President, Vice President and Legislature 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 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, now under the administration of the Office of Statistics, Budget, Overseas Development Assistance, and Compact Management (SBOC).

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 Title V Maternal Child Health (MCH) Program is one of the Five programs under the Family Health Services Section along with Title X Family Planning program, UNFPA Family Health Project, HRSA funded Early Hearing Detection and Intervention (EHDI) Programs, and State System Development Initiative (SSDI).

Title V Program Structure

The administration and management of the Title V Program is under the direct supervision of the National MCH Program Manager at the FSM Department of Health and Social Affairs, who provides guidance and works closely with each of the four State MCH Coordinators. Within each of the four States, under the direction of the State Director of Health, the Public Health Division administers the Title V Program. The MCH Programs provide primary care and preventive services to adolescents and women of childbearing age, education in the communities and schools, and counseling services to mothers during antenatal and postpartum clinics. The Title V Program will also prioritize and continue to strengthen its partnerships with relevant programs and stakeholders such as the National Immunization program, National Non-Communicable Disease (NCD) program, State Women Councils and other

National, State and Non-Governmental Organizations (NGO's).

Youth Suicide and Youth Mental Health in the FSM

The "2021 U.S. Pacific Asia Inquiry", Volume 13, Number 1, Fall 2022 115 DHHS report offers, as assessment, 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. (n.p.)

Reasons 1-3 appear to be external reasons while reasons 4-6 seem to be intra-cultural reasons for suicide; they also seem to be reasons that have been created or are derived from the discussions of suicide in the islands over the last 45-50 years.

As mentioned in the "Adolescent Suicide in the Federated States of Micronesia: A Literature Review" by Paulette M. Coulter Youth suicides and suicidal ideation are currently increasing in the U.S. and other developed and developing countries. Because the family is the initial core of culture in individual lives, the family must be the place to start. The research done by Francis X. Hezel and Donald H. Rubinstein had shown that conflict with someone in the family or with family expectations is often a precipitating event of suicide, and these conflicts may differ by island culture as well as by individual. Highest rate of Micronesian suicides occurs among males aged 15 to 24, and the preferred method is hanging, with death by anoxia. Anger and alcohol use may precede the suicide. For nearly fifty years Hezel and Rubinstein have collected data on more than a thousand suicides in Micronesia through records searches and through psychological autopsy.

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.

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

The Federated States of Micronesia had no confirmed COVID-19 cases during the initial outbreak of the pandemic and was among a few Pacific Island countries without positive cases and community transmissions. The novel coronavirus (SARS-CoV-2) that caused COVID-19 first emerged in the Chinese city of Wuhan in 2019 and was declared a pandemic by the World Health Organization (WHO) thereafter. This was a result of the Governments Healthy Border Protection Act which kept COVID-19 out of its borders despite a couple of confirmed cases in the fall of 2021 during repatriation flights and was detected at the quarantine sites in Pohnpei and Kosrae States. Until then, the FSM maintained the status quo of COVID-19 free through support and guidance from the World Health Organization (WHO) and the United States Centers for Diseases Control (CDC). However, in July of 2022 the first Community transmission was introduced and detected in the State of Kosrae and later in Pohnpei, Yap and Chuuk. By the latter part of 2022 all the FSM States detected community transmissions and COVID-19 deaths were reported in all the FSM States following the detection of confirmed cases in the States.

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 2024 Application/FY 2022 Annual Report Update

Based on the 2020 comprehensive FSM-wide needs assessment (NA), 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, 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.

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. 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, NCD Hybrid Survey Report, Surveillance Systems and Registries, Mortality Reviews, and other FSM agency data and reports.

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 next three-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 three-year time frame.

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 Application/Annual Report Review Summary highlights the strengths and challenges for FSM Title V program, based on the Fall 2022 review of FSM State Application/Annual Report.

"In response to the FY22 Application/FY2O Annual Report Block Grant review meeting, the Title V Program underwent a review of priority needs and associated measures. Although much improvement occurred among alignment of priorities, strategies, and measures, there remains instances in the FY23 Application/FY2l Annual Report and State Action plan in which alignment inconsistencies exist and measures can be further improved. For example, to support the Child Health priority, "improve child health through healthy weight through physical activity and nutrition promotion," the Program adjusted the strategy to, "do a weight contest among school children, 6-11years old, in schools." The corresponding Evidence-Based or -informed Strategy Measure (ESM) 8.1.1 reads, "percent of children ages 6 to 11 years old who participated in the evidence based and could be dangerous for children. The Perinatal/infant Health Domain narrative discusses the change from NPM 3, "percent of very low birth weight (VLBW) infants born in a hospital with a Level lll+ Neonatal intensive Care Unit (NICU)," to NPM 48, "percent of infants breastfed exclusively through six months;" however, the State Action plan table does not reflect this change. Furthermore, ESM 3 in the State Action Plan Table, "percent of low-birth-weight infants born in the hospital," does not support the new breastfeeding strategy and NPM.

The summary statement stated further that the MCH Program has experienced ongoing challenges related to compiling MCH program data. The States collect data and report to the National Government. However, it is evident that there were challenges that inhibit consistent and accurate reporting for MCH indicators, within the current structure of manual reporting. The Program intends to collect data in real time, in order to eliminate inconsistencies from year to year".

• Within the Women's Health domain, there are concerns as to how the Program plans to measure ESM 1.1, "percent of women, ages 18 to 44, attending community outreach events on preventive medical visits in the past year," as the numerator description does not provide a definition for "community outreach event."

• Within the Infant Health domain, NPM 3, "percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ neonatal intensive care unit (NICU) is not relevant for the FSM, as mentioned by the FSM Title V Program in the FY22 Application/FY20 Annual Report. Furthermore, ESM 3.1, "percent of low birthweight infants born in the hospital," does not align with the strategy that aims to "conduct community awareness workshops and events on the important of early pregnancy booking."

This NPM is not tracked by FSM. A new NPM 4 will be tracked in 2023 and 2024.

• Within the Child Health Domain, ESM 8.1.1, "percent of children ages 6-11 years old who are doing physical activity in schools at least 60 minutes daily before, during, and after the school day," is similar to the selected NPM 8.1, "percent of children, ages 6 through 11, who are physical active at least 60 minutes per day." Furthermore, the ESM does not indicate how the Program is implementing the strategy.

The strategy for objective for this ESM is to increase sports activities by providing sporting supplies and equipment to 1-6 graders in the schools. The Evidenced-Based Strategic Measure (ESM) is Percent of children ages 6 – 11 years old doing school physical activity at least 60 minutes per day and is actually recorded in the physical activity attendance sheet. The numerator is "Number of 6 – 11 years old who are recorded in the school physical activity attendance sheet" and denominator is "total number of children ages 6 – 11 in the schools". 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.

•Within the Adolescent domain, the newly added SPM 4, "percent of adolescents aged 12-17 years old who have attended educational awareness sessions on adolescent and behavioral health in schools," mirrors the ESM. In the CYSHCN domain, SPM 5, "percent of parents/caregivers receiving specialty trainings on CSHCN care coordination by 5%" is similar to ESM 11.1. Additionally, ESM 11.1 could be difficult to measure, as "receiving training" is not well defined".

The plan strategy for the SPM is to provide educational awareness in all the schools on the importance of well medical check-ups or health preventive visits.

The FSM MCH Program Annual meeting was held from June 29 to July 01, 2023. The agenda included: 2022 Annual Progress Report (guidance, development and submission); MCH Program; MCH Program 2024 Grant application; EHDI program and activities; SSDI program and activities; MCH Program Unobligated Funds; and Miscellaneous business.) This is for 2024 grant application.

The meeting was attended by the staff of the National and States MCH program staff including coordinators, Data clerks and CSHCN. Also in attendance were the; Pohnpei State Chief of Personnel and the Federal Programs Fund Certification Officer from Pohnpei State Finance office. They were invited to address FSM MCH Program's ongoing concerns over the large sums of money that Pohnpei has not been able to be spent this year among other administrative and financial issues within the MCH program.

The meeting started at 8:30 a.m. and ended at 4:30p.m. for the first two days and about 7 hours on the final day (Saturday). The meeting focused on the State's 2022 progress report and 2024 Grant application.

The group reviewed the progress reports for each of the FSM States and discussed areas of improvement that can be targeted for 2024 continuing application.

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 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.

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.

The priority for this domain is to improve women and maternal health through cervical cancer and anemia screening. The National performance measure (NPM) that was selected during the initial year was “percentage of women with a past preventive medical visit”.

Since cervical cancer is one of the leading causes of death for the women population in the FSM, the FSM MCH program prioritized cervical cancer screening by increasing Pap smear and VIA screening during a women's preventive visit so cervical cancer can be detected early and treated. As a result, a State Performance Measure was developed for this purpose. SPM #1 - Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening for the past year. Stock-out of supplies for cervical cancer screening is often listed as the underlying cause of low screening rates in the FSM states. Therefore, the FSM MCH Program developed a strategy “Assure availability of adequate supplies for continuous cervical cancer screening for all women 21-65 years old” to counter stock-outs of screening supplies. In 2022 all FSM States experienced challenges in addressing cervical cancer screening due to the prioritization and ongoing response of COVID 19. In addition, in the State of Yap health workers protested against the Government and services for cancer screening were interrupted.

All States in the FSM declared NCD as a public health emergency. Parallel thereto, the FSM MCH Program noticed an increase in women being diagnosed with anemia during pregnancy. In 20, 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 an effort to increase a woman’s health status, prior to pregnancy, the program instituted screening for all women for anemia. As a result, a State Performance Measure was developed for this purpose. SPM #2 - Percent of women (15-44 years old) screened for anemia for the past year. Stock-out of supplies for anemia screening is often listed as the underlying cause of low screening rates in the FSM states. Therefore, the FSM MCH Program developed a strategy to assure availability of adequate supplies for continuous screening of anemia for all women 15-44 years old and to counter stock-outs of screening supplies.

The two SPMs that were tracked during the reporting year continue to be tracked in 2023.

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

Percent	2020	2021	2022
FSM:	19.0%	2.3%	1.5%

Source: MCH Program Data

Table 2 Percent of women receiving a preventive medical visit

Percent	2020	2021	2022
FSM:	43.9%	37.9%	21.2%

Source: MCH Program Data

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

Percent	2021	2022	2022
FSM:	21.9%	21.9%	15.7%

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.

Perinatal/Infant Health:
The perinatal mortality rate in the FSM in 2022 was 23.9 per 1,000 live births; a tremendous drop from previous year. 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	2020	2021	2022
FSM:	39.7	49.8	23.9

Source: Vital Statistics

Generally, in 2022, 37.7% of mothers in the FSM reported exclusively breastfeeding their child at six months of age. This NPM was not carefully tracked in 2022 due to new NPM selected for the MCH programs. Although this is very low percentage in comparison to previous years, 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 2022, 18.4% 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 have improved significantly. One 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 boats or irregular shipping schedules.

The other challenge of increasing immunization coverages is due to parental or guardian consent. There are many things that contribute to lack of parental or guardian consent including cultural and religious believes as well as misinformation and disinformation. 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	2020	2021	2022
FSM:	68.4	64	70.6

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 citizen. 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 early to combat obesity and nutrition to prevent non-communicable diseases.

Currently developmental screenings are only completed on the MCH population but not the population at large. In 2022, only 4.7% 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 is decreased to 30.4 births per 1,000 females in 2022. 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 Pohnpei passed its first age of consent law at 18 years old.

Table 6 Rate of birth (per 1,000) for teenagers aged 15-17 years

Rate	2020	2021	2022
FSM:	31.4	30.4	22.4

Source: FSM Birth Certificate and Census Data

Teen births 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 Department 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 slowly improving.

	2020	2021	2022
Annual Rate:	62.0	7.1	1.3

Table 7 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 continues to work with other public health programs and youth groups in each State to meet these challenges among the adolescent population.

Risky adolescent behavior such as drug and alcohol use lead to injury such as motor vehicle accidents. Adolescent motor vehicle mortality rate, ages 15 through 19 was reported at 8.9 per 100,000 in 2020. Although not much data exists on current drug and alcohol use, it is believed throughout the communities 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 to the 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 8 Rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 19 years

Rate	2020	2021	2022
FSM:	8.9	16.7	0

Source: Hospital Discharge Records

Teen suicide is an issue in FSM with a rate as high as 25.1/100,000 adolescents being reported in 2021. However, the 2022 data shows a great decrease of suicide deaths among adolescents in the FSM. More awareness and education around suicide, its causes and prevention are necessary in the FSM.

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

Rate	2020	2021	2022
FSM:	17.8	25.1	8.4

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 especially among hard of hearing clients. In 2022, 5.3% of children were registered as CSHCN clients.

However, of those identified, 74% of children were receiving care in a well-function system according to 2022 data.

Table 10 Percent of CSHCN

Percent	2020	2021	2022
FSM:	4.4	2.7	5.3

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. However, specialty care and specialists in country continues to be a major problem in all FSM States.

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.

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.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$569,064	$519,806	$517,478	$521,427
State Funds	$440,000	$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	$1,009,064	$959,806	$957,478	$961,427
Other Federal Funds	$598,000	$585,000	$653,300	$653,300
Total	$1,607,064	$1,544,806	$1,610,778	$1,614,727

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$519,806	$523,967	$521,427	
State Funds	$115,000	$110,000	$115,000	
Local Funds	$816,225	$816,225	$816,225	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$1,451,031	$1,450,192	$1,452,652	
Other Federal Funds	$653,300	$653,300	$703,300	
Total	$2,104,331	$2,103,492	$2,155,952	

	2024	
	Budgeted	Expended
Federal Allocation	$528,967	
State Funds	$110,000	
Local Funds	$440,000	
Other Funds	$0	
Program Funds	$0	
SubTotal	$1,078,967	
Other Federal Funds	$703,300	
Total	$1,782,267	

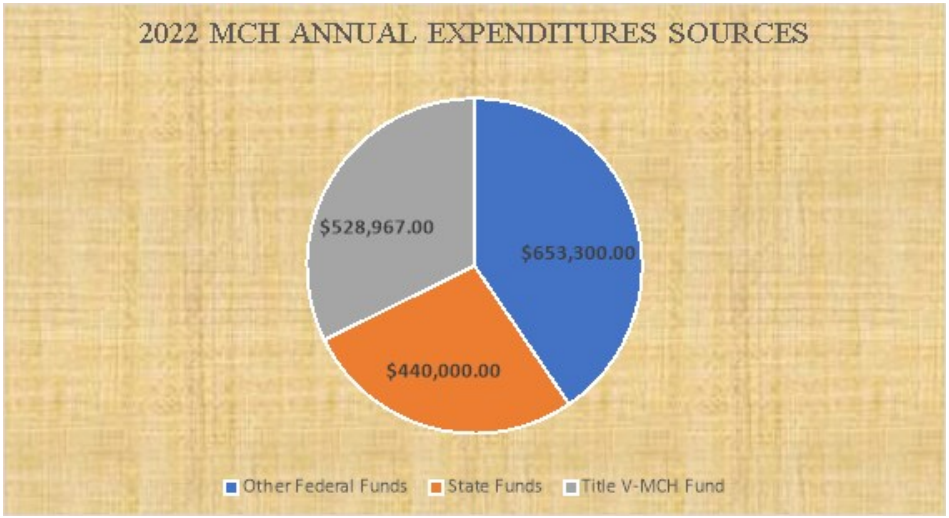
III.D.1. Expenditures

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 2022, from 10/01/2021 through 09/30/2023 the FSM MCH Program reported to have a total collaborative funds in the amount of $1,619,267. Of the total, $528,967 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 2022.



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

Title X Family Planning Program

Early Hearing Detection and Intervention (EHDI) Program

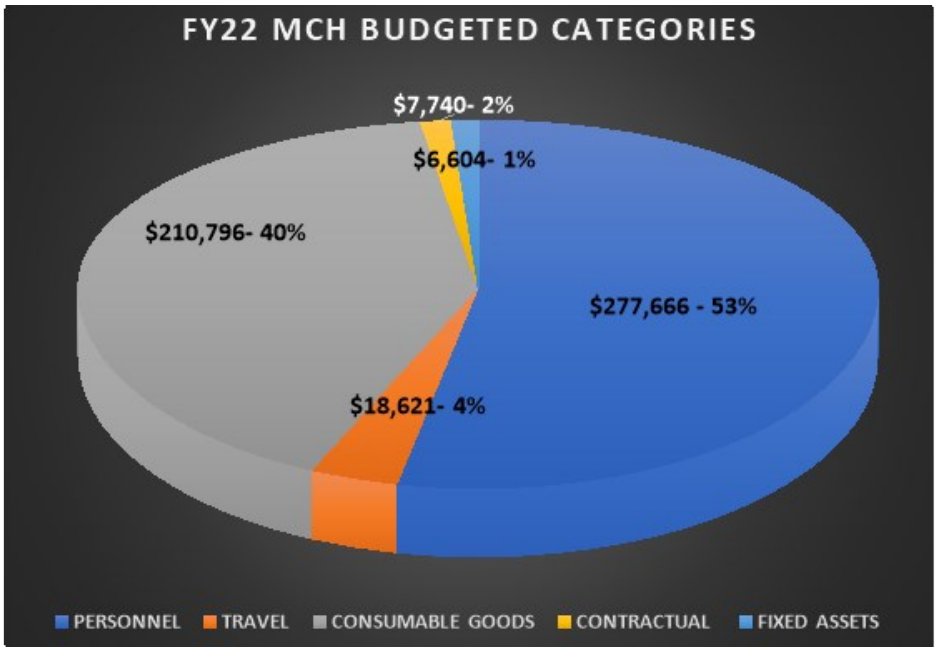
State Systems Development Initiative (SSDI) Project

USE OF THE TITLE V FUNDS

The chart, below, shows the 2022 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 2022.



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.

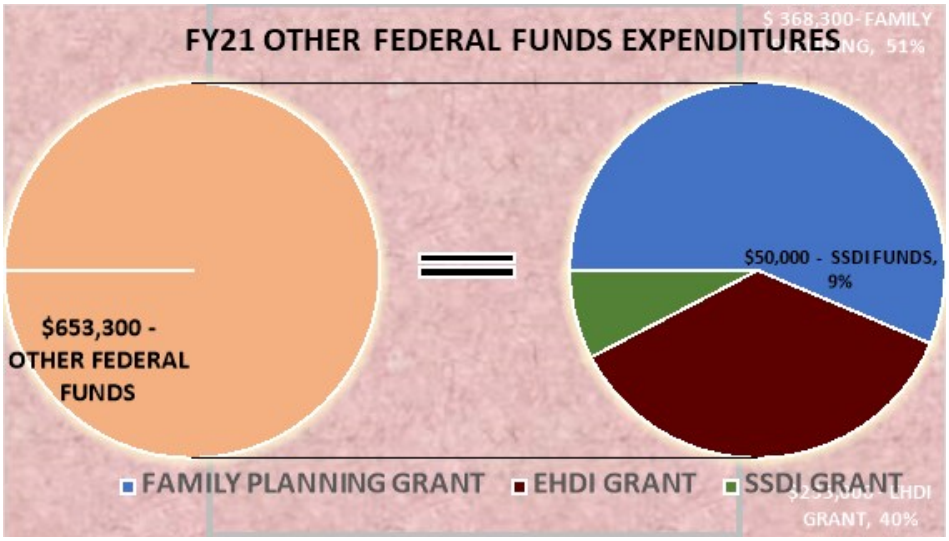
Based on expenditure report provided by the state department of finance in the Four FSM States including the FSM Investment Division showed that FSM MCH Program spent $158,284 or 31% on Preventive and Primary care for children, $159,132 or 33% on Children with Special Health Care Needs, and $42,157 or 6% on Administrative Costs. This shows that FSM MCH Program has not met the required legislative percentages of 30-30-10 for FY 2021. The remaining balance will spend not later than September 30, 2022.

The chart below provides an overview of the required federal allocation for the FY 21 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 2022 was $653,300.

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



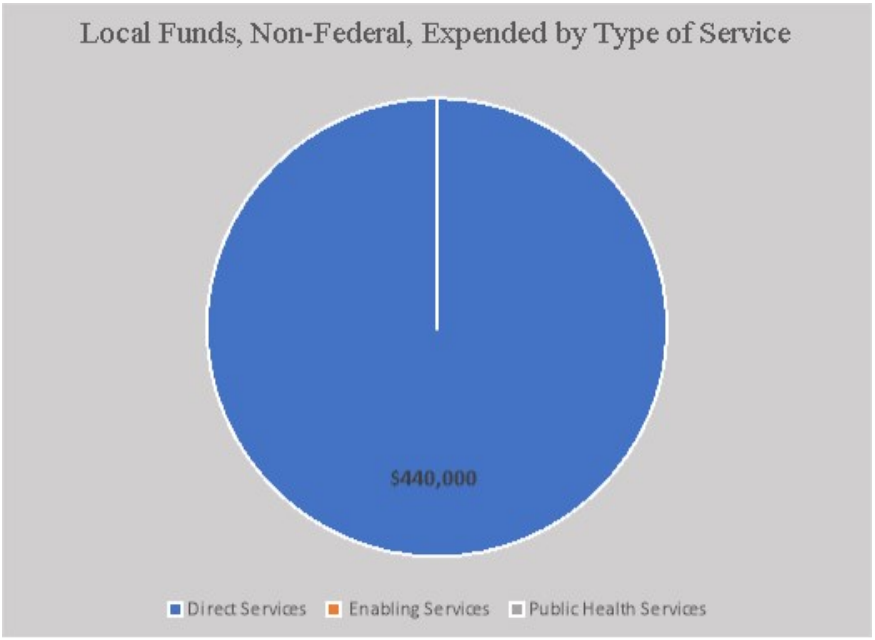
efforts for utilizing the life course framework in implementing programs and interventions to address the health and wellness needs and outcomes for the FSM MCH populations.

Total State Match

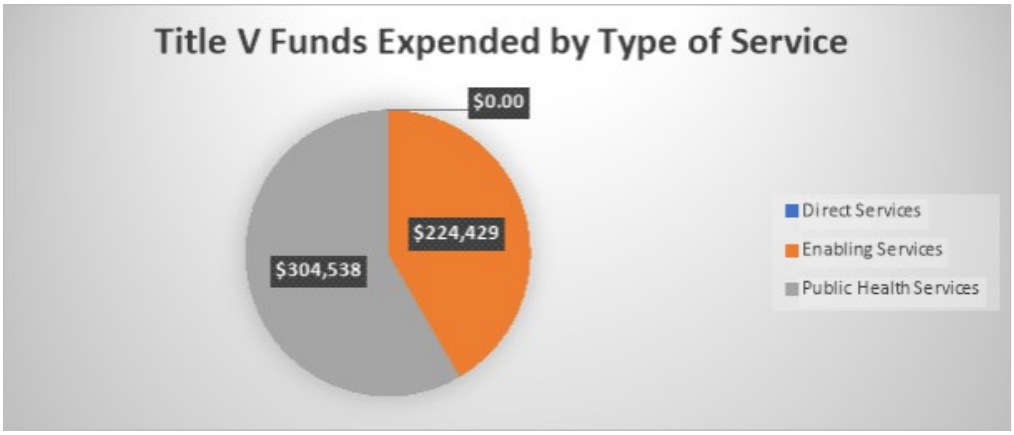
The total State Matching Funds in the amount of $440,000 is the required match requirement, which includes a $3

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 2022, 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.

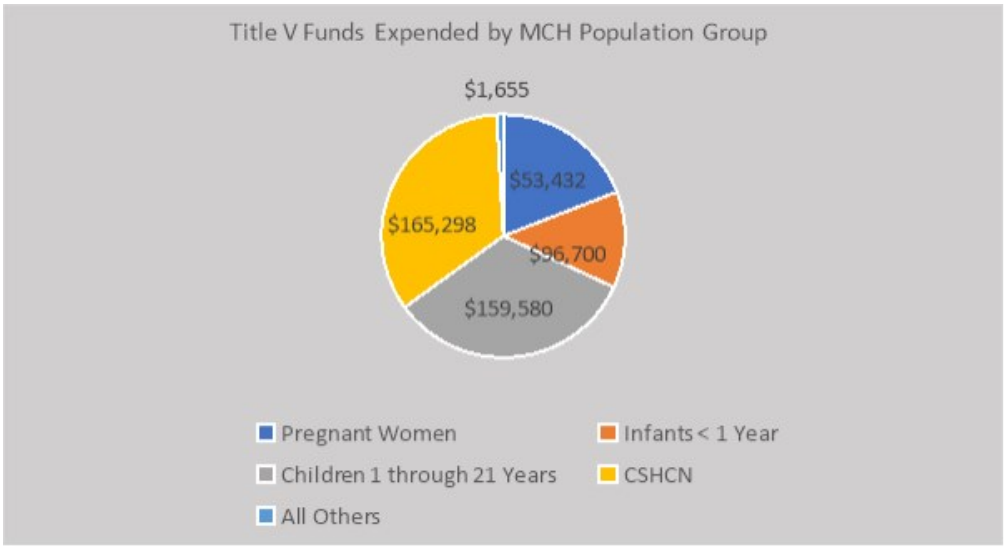


The chart below shows how the $528,967 of Title V MCH funds were expended by type of service as defined by the Title V guidance: direct, enabling and public health services and systems.

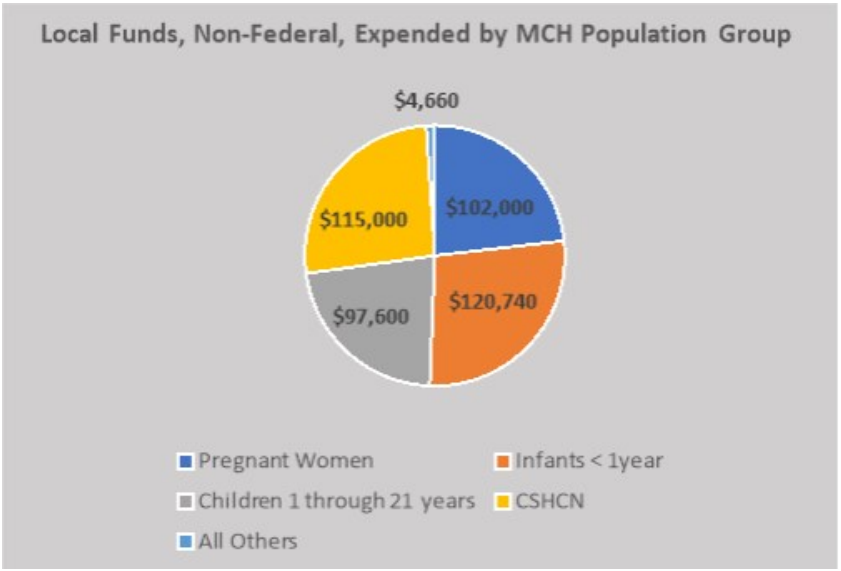


Expenditures by Population Group

The chart below shows how the $528,967 of Title V MCH funds were expended during this reporting period 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 Maternal and Child Health (MCH) Program in the Federated States of Micronesia (FSM) 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 2024 FSM is estimating a Total State MCH Budget of $1,782,267.

The 2024 State Action Plan for the MCH Program's was developed based on feedback provided in the 2023 MCH Block Grant Review Summary Statement. The FSM National & Sate MCH Program Staff reviewed the 2023 Review Summary Statement, on our own, and provided corrective actions by ourselves. The FSM MCH Program staff used the skills and knowledge gained during the 2020 TA Training to guide and facilitate the review process.

This year, is the first year after the Covid-19 Pandemic, that the FSM MCH Program again, have an In-Person Annual Planning Meeting. The initial plan was to have the Planning Meeting on June 1-3,2023, however our plan was aborted due to Typhoon Mawar, which battered Guam resulted in the cancellation of all United Flight from the Western Islands of the FSM for more than two weeks.

Again, this year, the FSM MCH Program's Annual Planning Meeting was implemented, eventually, during the last week of June 2023. The Working Workshop, as we called it, was held from June 29 to July 1, 2023. Topics for this year's workshop were limited to the MCH Program and they included: (1) FSM States' Progress Reports on the MCH Population Domains per the 2023 Action Plan; (2) 2023 Review Summary Statement and response; (3) MCH Program 2024 Action Planning; and (4) MCH Program Unobligated Funds.

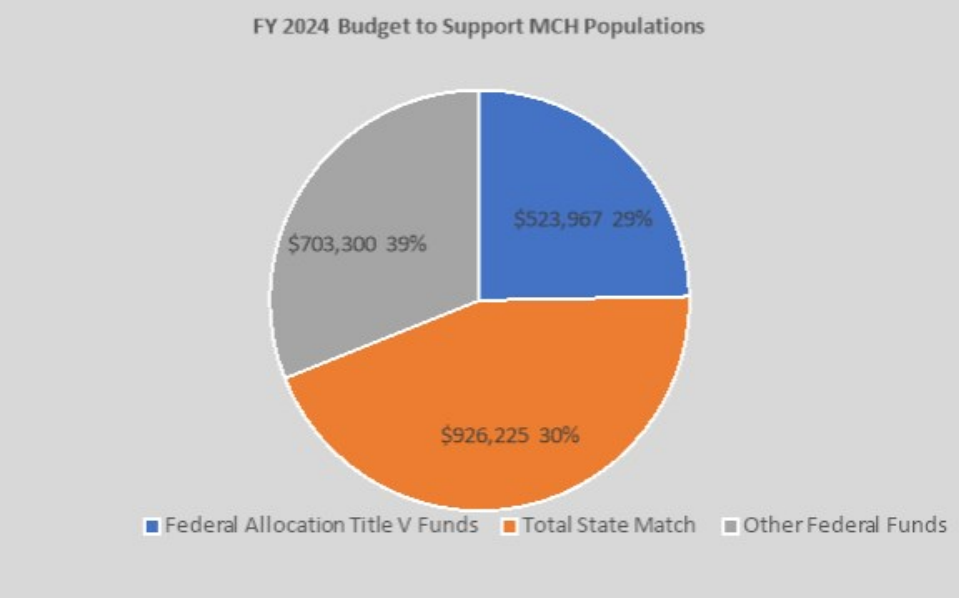
The meeting was attended by the staff of the National and State MCH Programs. Specifically, attending the workshop this year, from the State of Yap were the MCH and the CSHCN Program Coordinators. From Chuuk were the MCH & CSHCN Coordinators and the MCH Data Clerk. Attending from Kosrae, were the MCH Coordinator and the MCH Data Clerk. Since Pohnpei was the host and would not require participants to travel off-island, all MCH Program staff and other Public Health Program Coordinators and staff were invited to attend the workshop. However, the MCH Program Coordinator, the Follow-up Coordinator and the MCH Data Clerk are required to attend the full, 3-day workshop.

The workshop format was in both whole (big) group and small work groups. The sessions were combination of slide presentations on the Block Grant Program Requirements and the review of the FSM 2023 Grant Application Action Plan. The review of the action plan focused primarily on the State Priorities, National and State Performance Measures, Strategies, Evidenced-Based Informed Strategic Measures, Data Sources used, and discussion on ways to improve the alignment and effectiveness of priorities, NPMs, Strategies, ESMs and SPMs.

The whole group reviewed the summary statement to pinpoint areas needing improvements in the 2022 action plan. The whole group also looked at the jam boards developed during the 2020 Technical Assistance (TA) Training, which was facilitated by Dr. Haley Cash, to guide or assist development of effective strategies and sounds State Performance Measures and Evidenced-Based Strategic Measures (ESMs). The smaller work groups, grouped by population domain, actually worked on developing the 2023 MCH Program Action Plan. Other comments and recommendations made in the summary statement relating to the 2022 Action Plan were reviewed and acted upon to assure that strategies are specific or evidence-based in the 2023 action plan for all of the 5 MCH Population Domains. Therefore, the MCH Program's State Action Plan determines where the MCH federal grant dollars are budgeted.

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, Health Assistants, Graduate Nurses, 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 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, subscriptions, etc. The chart below provides an overview of the FSM MCH Program's FY 2024 Budget as reported on Form 2.

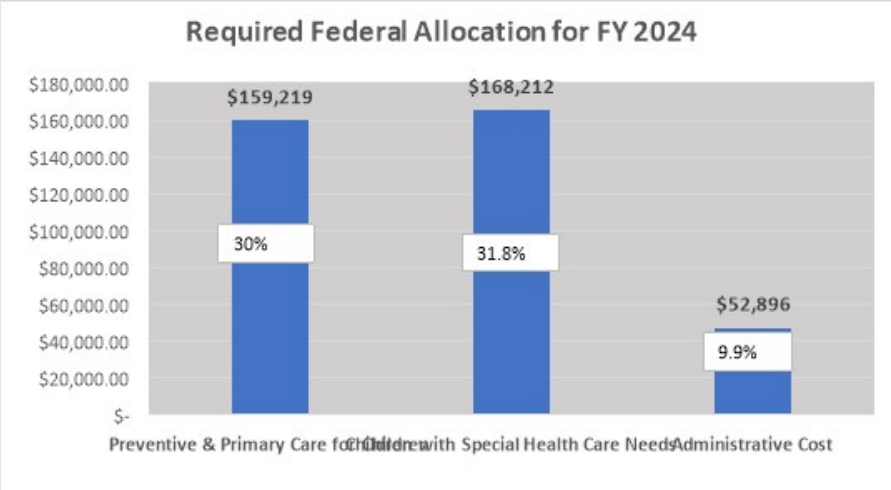


Legislative Requirements Met:

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.

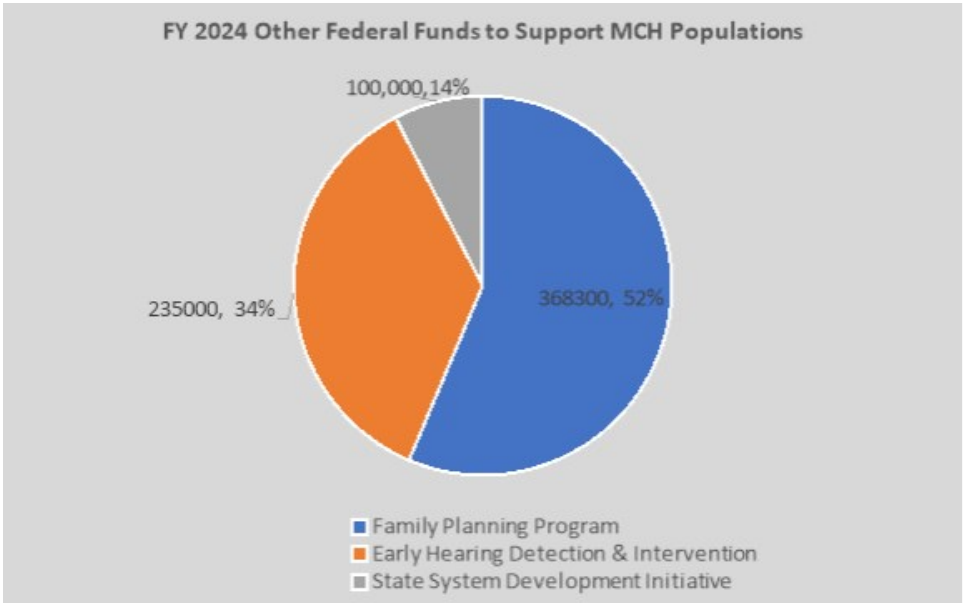
The Fiscal Year 2024 Title V Block Grant budget proposal of $523,967 consist of the following types of individuals served: Pregnant Women and Infants less than 1 year of age is budgeted at $143,980 which is at 27% of the total federal award. Preventive and Primary Care for Children is budgeted at $159,219 which is at 30% of the total federal award. Children with Special Health Care Needs is budgeted at $168,212 which is 31.8% of the total federal award. Administrative cost is budgeted at $52,896 which is 9.9% of the total direct costs of the federal grant award.

A total of $4,660 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 24 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 $703,300.



Total State Match

The FSM is in a unique situation where our matching requirement relative to the actual amount of Federal MCH dollars received is less than the MOE level in 1989. During the Financial Technical Assistance (TA) Training, held in Pohnpei, FSM in February 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 the total amount of funds budgeted 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

State Title V Program Purpose and Design

The mission of the Family Health Service unit 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.

The foundation of the Title V program describes key areas required for designing the MCH programs: including developing goals and understanding the circumstances to inform service design. The MCH programs had a common goal: to improve health outcomes for pregnant women, newborns, children with and without special health care needs, adolescents and their families. The FSM nation set several specific goals for knowledge, behavior change and increased service utilization. An important element of groundwork is to document the service delivery points, gaps, and potential linkages to evidence-based strategies and interventions.

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 FSM MCH Program has planned for and will continue to implement a community-based approach to the delivery of MCH program services and related preventive health services. This involves bringing maternal and child health services, health education and screening programs directly to residents of the areas. The services will continue to be conducted at public health clinics, community clinics, local parish halls, schools, community centers and sports facilities in close cooperation with more than ten local community organizations. FSM MCH program chose a conceptual framework 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 impact of the MCH Block Grant funding and services reach far into the entire MCH Population in the FSM and further augment the way the health delivery system is structured to provide care.

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

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

MCH Workforce Development

Assessing the Workforce Capacity of the FSM MCH Program, in 2022, 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 who manage and oversee the FSM MCH Program and services on a daily basis. These senior and key staff directly provide all of the preventive and primary health care services at no cost to clients. They are also involved in the management and operation of the Title V needs assessment and application processes every five years and annually, thereafter.

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, Missour 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.

National Child Protection and EHDI Follow up Coordinator, Family Health Services Unit, Division of Health Services, FSM Department of Health and Social Affairs: Mr. Johnny Hadley holds a Bachelor of Arts Degree in Economics from University of Hawaii in 1998. His job duties: Assist with the Development of a National Child Protective Service in line with the Social and Cultural Practices of the FSM States and related Local, Regional and International practices; Act as Secretariat to the President's National Advisory Council on Children (PNACC) on behalf of the National Department of Health and Social Affairs.

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. Wefonne Billen holds her BA degree in Public Health at Fiji University, and is the EHDI follow up coordinator prior to taking up this coordinator post.

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. Rolmy Hasugoiram is a nurse by profession, and the EHDI coordinator for Yap state prior to this post.

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 Associatior 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 which is funded through the Title V Maternal and Child Health (MCH) Program understands the importance of family and consumer partnerships as a mechanism to strengthen MCH programming at the National and State levels. The Title V Block Grant defines family/consumer partnership as "patients, families, their representatives, and health professional working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy making— to improve health and health care. This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course."

The FHS Unit accomplishes this objective through its internal and external collaborations to improve services for the MCH populations especially in the underserved communities and outer islands. Partner programs and services include the family planning outreach, breastfeeding promotion, the Diabetes, Cancer and Non-Communicable Disease (NCD) program (tobacco cessation, nutrition, breast and cervical cancer screening, diabetes prevention and education), the Behavioral and Wellness Program (substance abuse and Mental Health Disorders) and the National vital statistics unit among others. The FHS partners with organizations in the FSM to develop culturally specific, relevant, and actionable policies and programs that serves its residents with a goal of improving the mental health and wellness of individuals and achieving health equity.

The time needed to develop the partnerships varied greatly among affiliated programs and agencies based on the lead implementing partner, relationships with government and non-government and other resource partners. Hence, FHS partnerships are developed and continues to be strengthened based on existing working relationships and collaborations.

However, challenges still exist among potential and new partnerships. This is evident when the roles and responsibilities of the parties involved are unclear and changes in government priorities and management occur. In November 2020, the FHS redesigned its partnership objectives to clarify roles and responsibilities of the founding partners and to articulate a collaboration mechanism between the implementation partners (state public health programs) and with various government agencies and other resource partners.

Family/consumer engagement has taken place through advisory committees, strategic and program planning, quality improvement, workforce development, block grant development and review, 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 FHP Program has, over the years, supported learning collaboratives 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 at the State levels to support this activity. 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 FHS program and its 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.

The public health issues affecting MCH outcomes generally affect low-income and minority populations disproportionately and is influenced by the physical, social and economic environments in which people live. To address these complex health issues effectively, the FSM Title V program recognizes that a spectrum of strategies to build community capacity and promote community health must include parents and consumers representing the affected populations as integral partners in all activities in order to have full community engagement and successful

programs. In order to carry out these functions and address the public health disparities affecting FSM's maternal child health population.

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

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

MCH Epidemiology Workforce

Due to widespread of Covid-19 illness in 2022, there were limited MCH activities including epidemiological work that the National and State MCH staff performed in their respective States.

FSM MCH needs Epidemiology training for staff to build 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. The FSM government needs sufficient high-level epidemiological trainings provided to local staff who essentially will build capacity in the health and educational arena.

To enhance the epidemiological workforce in the four FSM State MCH programs, a training on the new MCH Data web-based system took place in February 2023. All the MCH data clerks and coordinators along with relevant MCH nurses attended the training that was conducted by one of the developers from the FamilyTrac company who actually design and established the FSM MCH data web-based system. The system is in place now and is linked to the FSM HER EHDI system.

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

State Systems Development Initiative (SSDI)

The FSM-MCH project provides the critically needed funding that makes a major difference for the health of women and children, including those with special health care needs, and their families in the FSM. Each year, on the average, about 1900 pregnant women, 1800 newborns, 33,000 children aged 1 through 14, and 1500 children with special health care needs are served by the FSM MCH Program. Although challenges continue with data collection and reporting, in the last 5 years, major obstacles were overcome with development of the first data web-based system which captures data on the Newborn Hearing Screening, which allow hearing screening data to be collected and reported electronically.

To understand the challenges and context of the FSM to deliver MCH Program services to mothers, the newborn infants and their families, a brief review of the geographical location, political status, socio-economic status, population, educational level, fertility/birth rate, and the significant ethnic and linguistic diversity of the FSM is necessary. The FSM is an island nation with a total population of approximately 107,008 spread out over some 607 widely dispersed islands in the Western Pacific Ocean. The many islands which compose the FSM vary from large, high mountainous islands of volcanic origin to small flat, uninhabited atolls.

The FSM is a constitutional federation incorporating four main states: (1) Pohnpei State, (2) Kosrae State, (3) Chuuk State, and (4) Yap State. Each state has an island center located in the state capital. The capital of Yap State is on the island of Colonia, in Chuuk State, the island capital is located on Moen, in Pohnpei state, the island capital is located in Kolonia. Surrounding each of these three states are sparsely inhabited outer islands. Kosrae State is the only FSM State composed of a single island. Politically, the FSM is a 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.

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 most recent Needs Assessment was conducted in 2020. This needs assessment requires ongoing sources of information about maternal and child health (MCH) status, risk factors, access, capacity and outcomes. Needs assessment of the MCH population is an ongoing collaborative process, one that is critical to program planning and development and enables the state to target services and monitor the effectiveness of interventions that support improvements in the health, safety and well-being of the MCH population.

During June 2023, the FSM National and State MCH Program Coordinators, MCH Data Clerks and key program staff met, virtually, to agree to a way forward to complete and submit the 2022 annual report and 2024 action plan for the FSM MCH Program. The plan, for this year, was to have an in-person MCH Annual Planning Meeting. The MCH Annual Planning meeting was part of FSM's commitment to continue to systematically assess needs of the various MCH populations, each year, during the next five years. 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 2022 MCH Block Grant Review Summary Statement. The States collect data and report to the National Government; however, it is evident that there are challenges that inhibit consistent and accurate reporting for MCH indicators, within the current structure of manual reporting. The Program has a desire to collect data in real time, in order to eliminate inconsistencies from year to year.

The Work Plan for the FSM SSDI Program has four goals, and two Objectives. The activities will enable FSM SSDI project to meet the targets which will ultimately lead FSM toward achieving the 4 goals. 1). Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming; 2). Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy

development, and assure and strengthen information exchange and data interoperability; 3) Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming; and 4) Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19. The purpose is to achieve its mission of improving the health and well-being of FSM's mothers, children, and families. MCHB Overall Objective #2, Medicaid Data, is not Applicable to FSM since we are not eligible for either Medicaid or Medicare.

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.

The FSM MCH Program has planned for and will continue to implement a community-based approach to the delivery of MCH program services and related preventive health services. This involves bringing maternal and child health services, health education and screening programs directly to residents of the areas. The services will continue to be conducted at public health clinics, community clinics, local parish halls, schools, community centers and sports facilities and local community organizations. FSM MCH program chose a conceptual framework 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 impact of the MCH Block Grant funding and services reach far into the entire MCH Population in the FSM and further augment the way the health delivery system is structured to provide care. The outcome results of all these activities will be shown in the data collection of the ESM, NPMs, NOMs and SPMs.

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

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 NPMs, SPMs and ESMs. 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 was established and rolled out in February 2023 of this year. This new online system will enable the FSM MCH programs to collect, store and report the MCH data for decision making and enhancing provided services to the MCH population.

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

There were several MCH products that were distributed to other government offices and agencies for reporting purposes and information use.

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. However, the FSM Disaster Response Plan does not incorporate inclusive and response requirements specific to Women and Children (pregnant, postpartum, and/or lactating and infants and young children).

Additionally, the FSM has yet to put in safeguards and periodic implementation programs to slowly address health issues resulting from Climate variability and change. Based on the National Climate Change and Health Action Plan (NCCHAP) the FSM started experiencing health vector-borne diseases, water-borne diseases and malnutrition, followed by zoonotic infections, mental health problems, non-communicable diseases and respiratory diseases. FSM needs to prioritize adaptation measures in order to minimize and avoid climate change-attributable health risks. In doing so, it is hoped that the health system in the Federated States of Micronesia may be strengthened and the level of cross-sectoral cooperation improved, as climate change is truly an issue that ignores traditional boundaries of roles and responsibilities.
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. This is also the same situation for Covid-19 emergency and preparedness campaigns in all the four FSM States.

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

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.

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

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 2024 and beyond.

Following is the FSM 2024 Action Plan based on findings made and reported in the 2022 MCH Data Matrix and 2022 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 with additional and minor changes to few SPMs.

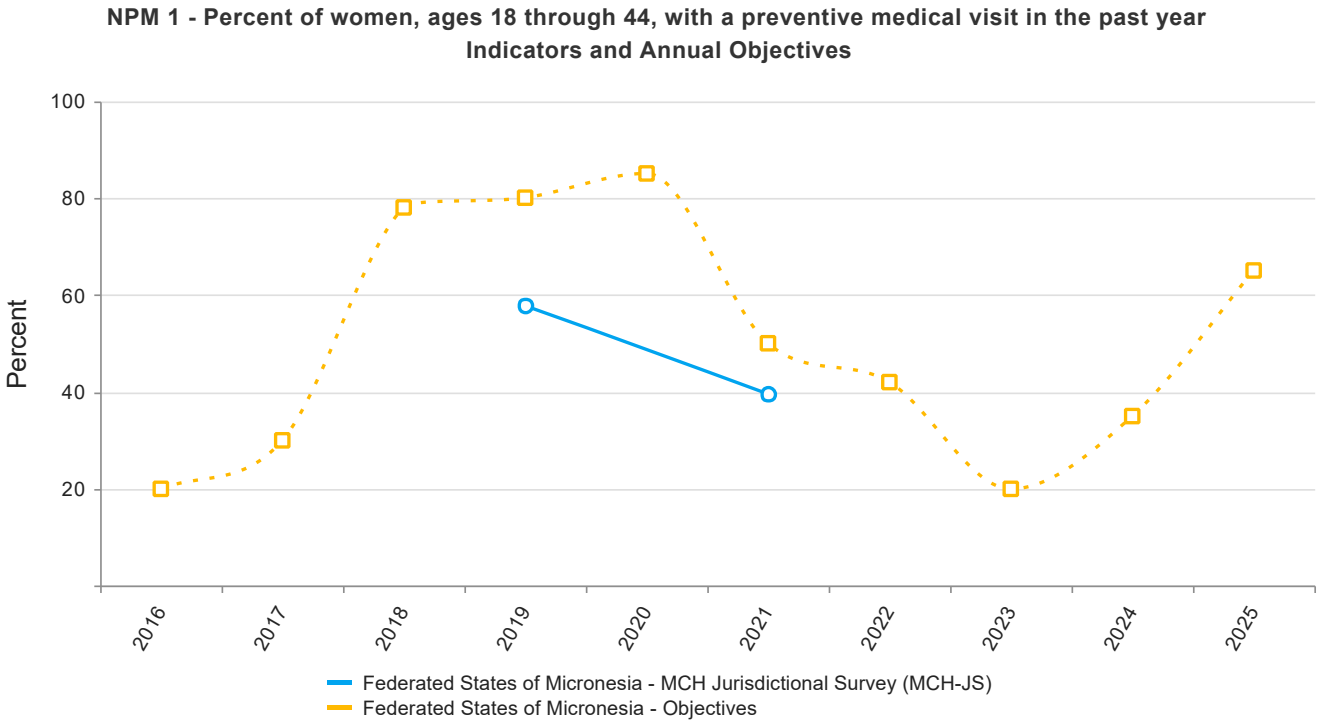
2024 FSM MCH ACTION PLAN					
Domain and State Priority Needs	**NATIONAL OR STATE PERFORMANCE MEASURE**	**Objective**	**NPM or SPM Strategies**	**Evidence-based/-informed Strategy Measure (ESM)**	**Numerator/ Denominator**
Women/Maternal Health					
Priority 1. Access to health services- Improve women's health through cervical cancer and anemia screening	SPM-Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.	1. By 2024, increase percentage of women ages 21-65 years who received a Pap or VIA and anemia screenings by 5%.	Assure availability of adequate supplies for continuous cervical cancer screening for all women 21-65 years old" Assure availability of adequate supplies for continuous screening of anemia for all women 15-44		*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

			years old		
	SPM- Percent of women (15-44 years old) screen for anemia for the past year	2. By December 2024, Increase percentage of women with childbearing age who received anemia screening by 15%.	Assure availability of adequate supplies for continuous screening of anemia for all women 15-44 years old		*Number of women (15-44 years old) screen for Anemia.* Total number of women (15-44 years old) in the state
Perinatal					
Priority 2. Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening	SPM - Percent of pregnant women who received early and adequate prenatal care services beginning during the first trimester including gestational diabetes screening by 24-28 weeks.	By 2024, increase the rate of pregnant women receiving prenatal services in the 1st trimester of pregnancy by 45%.	To conduct at least 5 community awareness sessions (workshops, radio spots) on the importance of early pregnancy booking		*Number of pregnant women at 20 to 24 weeks who are screened for gestational diabetes*
		By 2024, increase the percent of pregnant women screened for gestational diabetes by 45%	Ensuring inventory of GDM testing is adequate and that GDM is included in the Prenatal procedure and manual		The total number of pregnant women during the reporting year.
Child Health					
Priority 3. Improve child health through healthy weight through physical activity and nutrition promotion	NPM #8.1 Physical Activity: 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 85% at the end of 2024	To increase sports activities by providing sporting supplies and equipment to 1-6 graders in the schools	Percent of children ages 6 – 11 years old doing school physical activity at least 60 minutes per day and is actually recorded in the physical activity attendance sheet	*Number of 6 – 11 years old who are recorded in the school physical activity attendance sheet* Total number of children ages 6 – 11 in the schools
Adolescent Health					
					Number of 12-17

Priority 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 outcomes (i.e. teen pregnancy, injury, suicide)	SPM - Percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools	By 2024, increase the percentage of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools that actually received a well-adolescent visit by 35%.	To provide educational awareness in all the schools on the importance of well medical check-ups or health preventive visits.		*years old attended education on adolescent's health during the past school year who actually visited the clinics for a preventive medical service* Number of 12-17 years old in the schools who attended educational awareness sessions in the schools on the importance of well medical check-ups or health preventive visits
Children with Special Health Care Needs					
Priority 5. Provide care coordination training for parents/caregivers of Children with Special Health Care Needs	Percent of parents/caregivers received and completed training in Care Coordination of services for children with special health care needs (CSHCN)	By December 2024, increase the percentage of parents /caregivers receiving specialty trainings in care coordination of services for CSHCNs by 50%.	Work collaboratively with specialists/ specialized trainers to provide more and continuous care coordination training to CSHCN parents/caregivers in the FSM States.		*Number of parents/caregivers receiving trainings on care coordination for CSHCN* Total number of parents/caregivers during the reporting year

Women/Maternal Health

National Performance Measures



Federally Available Data				
Data Source: MCH Jurisdictional Survey (MCH-JS)				
	2019	**2020**	**2021**	**2022**
Annual Objective		85	50	42
Annual Indicator	57.8	57.8	39.4	39.4
Numerator	9,102	9,102	10,553	10,553
Denominator	15,758	15,758	26,751	26,751
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	78	80	85	50	42
Annual Indicator	73.8	57.8	43.9	39.4	11.2
Numerator	7,074	9,102	3,046	10,553	2,068
Denominator	9,589	15,758	6,940	26,751	18,428
Data Source	MCH Program	MCH Program	MCH Program	MCH-JS	MCH Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	35.0	65.0

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

State Provided Data				
	2019	2020	2021	2022
Annual Objective				15
Annual Indicator			10.2	11.2
Numerator			1,652	2,068
Denominator			16,216	18,428
Data Source			MCH Programs	MCH Program and 2020 Census
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	30.0	40.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			7
Annual Indicator		2.3	1.5
Numerator		557	373
Denominator		24,576	25,621
Data Source		FSM Data Matrix	MCH Program and Census
Data Source Year		2021	2022
Provisional or Final ?		Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	12.0	15.0	20.0

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	75	22	27	20	25
Annual Indicator	19.4	14.6	10.8	10.8	9
Numerator	4,384	384	2,526	2,509	1,975
Denominator	22,610	2,629	23,492	23,270	21,872
Data Source	MCH program and Census	MCH program	MCH Program	FSM Data Matrix	MCH Program and Census
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	35.0	40.0

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 2023, 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 cervical cancer and anemia screening.	
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 2023, increase the percentage of women ages 21-65 years who received a Pap or VIA screenings by 4%.

Strategies

Assure availability of adequate supplies for continuous cervical cancer screening for all women 21-65 years old

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 2023, increase anemia screening in childbearing age women (15-44 years old) by 4%.

Strategies

Assure availability of adequate supplies for continuous anemia screening for all women 15-44 years old

Women/Maternal Health Plan – 2022 Annual Report

The selected priority for this domain is to improve women and maternal health through cervical cancer and anemia screening. The National performance measure that was selected in the initial year during this new MCH cycle was percentage of women with a past preventive medical visit -NPM#1. The data for this NPM is reported using the FAD from the MCH Jurisdictional survey conducted in 2021. During the previous years, FSM MCH program reported data that are trackable by State performance activities. The same SPMs selected in 2021 was continue to be implemented in 2022. In 2022, the MCH Jurisdictional survey was completed and FAD for this NPM1 is being used for this domain in the TVIS. The two selected and implemented SPMs for women/maternal health domain in the past year were: Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening and Percent of women (15-44 years old) screen for anemia for the past year.

Cervical cancer is one of the leading causes of death in the women population in the FSM since the 1990's. 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 2022 data shows that cervical cancer screening among women ages 21-65 years of age was dropped from 2.3% in past year to 1.5% in the reporting year.

2022 SPM			
New MCH Cycle - 2022 FSM MCH DATA MATRIX			
		FSM 2022	Rate
SPM 1- Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening.	Number of women ages 21-65 years old who had Pap or VIA screening in the past year	**373**	***1.5%***
	Total number of women ages 21-65 years old in the State	**25,621**	

There was less or no screening done in the field during outreach activities due to no private place available to perform cervical cancer screening, and inappropriate cultural issues that women in the communities had encountered. Community awareness activities were not possible during the year due to COVID19 prevention restrictions and activities. COVID19 vaccination started, so the health department was focused on ensuring proper vaccination coverage for the population. All staff were assigned to vaccination activities in the morning (or trips to OI and weekend vaccination campaigns) and running regular clinics in the afternoons, leaving no time for outreaches or other activities.
In 2022, 9 percent of women ages 15-44 years in the FSM have screened for Anemia at the State hospitals, Public health and CHC centers. 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 FSM MCH Program noticed that women being diagnosed with anemia occurred during pregnancy.

MCH and other Public Health programs and CHCs had conducted cervical cancer and anemia screening to all women who participated one-time event during the year, like the Women's Day and Cancer Day. During the reporting year, there were more women who seek preventive services at Public Health and CHCs and also received awareness on the importance of anemia and cervical cancer screening.

The MCH programs continued to partner with Cancer Program and other related programs in initiating the HPV DNA project. Amid the struggles of ensuring herd immunity in the community against COVID19, the core HPV Project group continued to meet during lunch hours for the planning purposes of this project. The aim is to eventually do away from the invasive screening methods of cervical cancer, and focus more on those with high risk, per DNA HPV

results. The shame of exposing self and the culture surrounding the male health providers providing these types of services to the female population had always been some obstacles in cervical cancer screening. HPV DNA screening(self-collection) will certainly eliminate these challenges. The major planning phase of this project was completed last year and aims for launching again in the year 2023. This project is implemented in Yap, and the State is very fortunate to have this opportunity, as this may be the way to have more women screened due to the nature of this testing and hopefully eliminate cervical cancer in the state. Hopefully, the end result of this project will cover the loss of cervical cancer screening the whole two years of this pandemic.

Somehow during this pandemic, and probably due to the interruption of clinics, cervical cancer screening has become more of a physician referral case based on previous results and present complaints; thus, an increase of 8.8% in 2022. COVID19 vaccination started, so the health department focused on ensuring proper vaccination coverage for the population. All staff were assigned to Covid-19 vaccination activities in the morning (or trips to OI and weekend vaccination campaigns) and running regular clinics in the afternoons, leaving no time for outreaches or other activities on cervical and anemia screening.

Women/Maternal Health - Application Year

Women/Maternal Health Plan – FY 2024

Similar to last year's plan, the plan for 2024 remains the same. The priority for this domain is "Access to health services – "improve women's health through cervical cancer and anemia screening". The National performance measure (NPM) that was selected during the initial year was "percentage of women with a past preventive medical visit". Preventive medical visit, in our opinion, was too broad and it would be difficult for the FSM MCH program to track, collect data and report on. Therefore, FSM selected cervical cancer screening and anemia screening as proxy measures for Women Preventive Medical Visit.

Since cervical cancer is one of the leading causes of death for the women population in the FSM, the FSM MCH program wishes to prioritize cervical cancer screening by increasing Pap smear and VIA screening during a women's preventive visit so cervical cancer can be detected early and treated. As a result, a State Performance Measure was developed for this purpose. SPM #1 - Percent of women ages 21-65 years old receiving cervical cancer (Pap & VIA) screening for the past year". Stock-out of supplies for cervical cancer screening is often listed as the cause of low screening rates in the FSM states. Therefore, the FSM MCH Program developed a strategy "Assure availability of adequate supplies for continuous cervical cancer screening for all women 21-65 years old" to counter stock-outs of screening supplies. The FSM MCH Program is convinced that with adequate screening supplies our target of 5% increase for all women 21-65 years of age screened will be achieved as stated in our objective for 2024. Numerator is the "number of women ages 21-65 years old who had Pap or VIA screening in the past year" and denominator is "total number of women (21-65 years old)".

All States in the FSM has declared NCD as a public health emergency. Parallel thereto, 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. As a result, the State Performance Measure was developed for this purpose. Next years SPM is similar to last year tracked measure SPM #2 - Percent of women (15-44 years old) screened for anemia for the past year. Stock-out of supplies for anemia screening is often listed as the underlying cause of low screening rates in the FSM states. Therefore, the FSM MCH Program developed a strategy "Assure availability of adequate supplies for continuous screening of anemia for all women 15-44 years old" to counter stock-outs of screening supplies. The FSM MCH Program is convinced that with adequate screening supplies our target of 15% increase of women screened for anemia will be achieved. Numerator is "number of women ages 15-44 years old screened for anemia in the past year: and denominator is "total number of women (15-44 years old)".

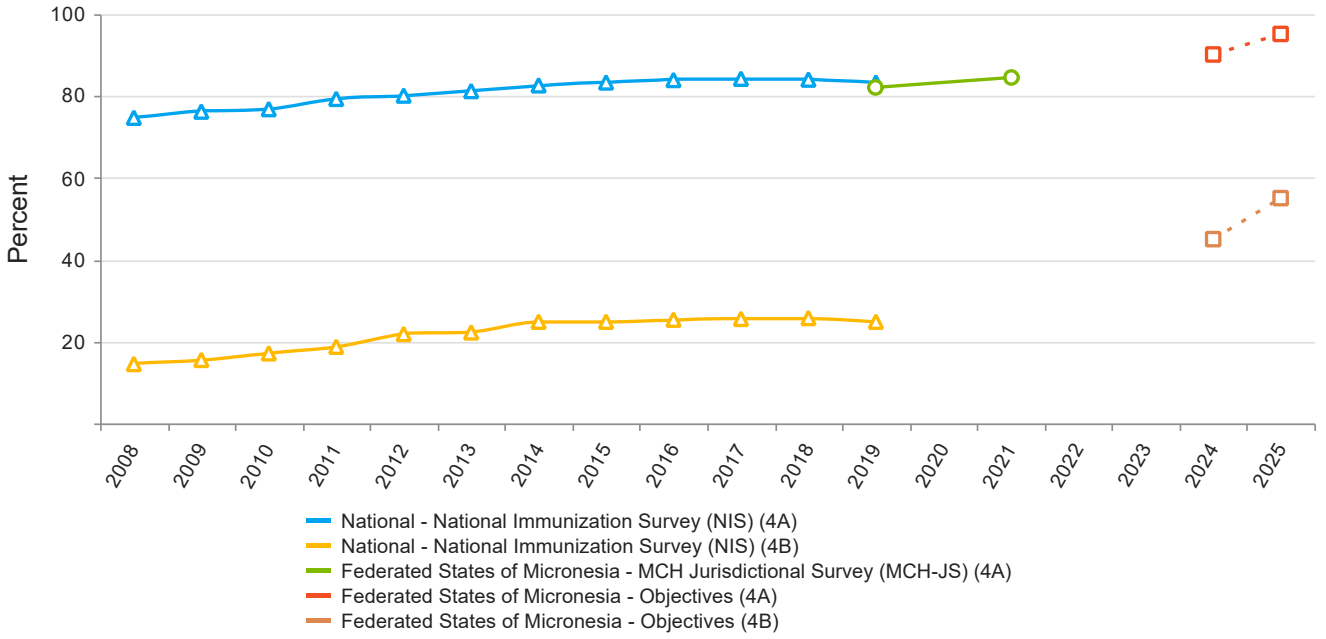
The two SPMs were developed during the previous year however due to the importance of cervical cancer and anemia screening for the women population in the FSM the SPMs will be continued in 2024.

2024 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 for the past year"	By 2024, increase the percentage of women ages 21-65 years who received a Pap or VIA screenings by 5%.	Assure availability of adequate supplies for continuous cervical cancer screening for all women 21-65 years old"	Number of women ages 21-65 years old who had Pap or VIA screening in the past year. Total number of women (21-65 years old).
	Percent of women (15-44 years old) screened for anemia for the past year.	By 2024, increase anemia screening in childbearing age women (15-44 years old) by 15%.	"Assure availability of adequate supplies for continuous screening of anemia for all women 15-44 years old"	Number of women ages 15-44 years old screened for anemia in the past year/ Total number of women (15-44 years old).

Perinatal/Infant Health

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2022
Annual Objective	
Annual Indicator	84.5
Numerator	10,853
Denominator	12,850
Data Source	MCH-JS
Data Source Year	2021

Annual Objectives		
	2024	**2025**
Annual Objective	90.0	95.0

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

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

State Provided Data	
	2022
Annual Objective	
Annual Indicator	37.7
Numerator	632
Denominator	1,677
Data Source	MCH Data Matrix
Data Source Year	2022
Provisional or Final ?	Provisional

Annual Objectives		
	2024	2025
Annual Objective	45.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of new mothers who attended breastfeeding group workshops

Measure Status:	Active
State Provided Data	
	2022
Annual Objective	
Annual Indicator	37.7
Numerator	632
Denominator	1,677
Data Source	MCH Program and Vital stats
Data Source Year	2022
Provisional or Final ?	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	45.0	75.0

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			30
Annual Indicator		27.1	15.8
Numerator		458	253
Denominator		1,687	1,600
Data Source		FSM Data Matrix	MCH Program and Vital stats
Data Source Year		2021	2022
Provisional or Final ?		Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	35.0	40.0	45.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Perinatal/Infant Health - Entry 1	
Priority Need	
Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening and promoting breastfeeding	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
By 2025, increased percentage of infants exclusively breastfed up to six months old by 75%	
Strategies	
Breastfeeding support groups to provide breastfeeding services in the communities.	
ESMs	Status
ESM 4.1 - Percent of new mothers who attended breastfeeding group workshops	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) 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 and promoting breastfeeding

SPM

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

Objectives

By 2023, increase the rate of pregnant women receiving prenatal services in the 1st trimester of pregnancy by 35%.

By 2023, 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

Perinatal/Infant Health

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

The perinatal mortality rate in the FSM in 2022 was 23.9 per 1,000 live births, which decreased from 2021. 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. About 22 percent of pregnant women attended prenatal clinic beginning of the first trimester last reporting year. Adequate visits are measured by the Kotelchuck Index in which the numbers of visits are marked at or above 8 prenatal visits.

Lack of screening for gestational diabetes during prenatal care effects newborn outcomes. About 3.2% of pregnant women receiving services at the MCH program were found to have gestational diabetes in 2022.

All pregnant mothers at first visit within the 24-28 weeks are screened with GTT. 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.

In 2022, the percent of Anemia in infant was 3.6%. There were several home births and loss to follow up babies referred to Well Baby Clinics due to inaccessibility of services at the dispensaries in the remote areas, specifically the outer islands.

Most of the babies who were born in 2022 have had their hearing screening by OB nurses or MCH screeners at the hospital and at the MCH program units. Overall, 67.2% of all newborns had hearing screening in the past year. 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.

Pregnant women who received dental screening in 2022 was 76%. Despite the negative impacts to MCH services during the COVID 19 pandemic the data showed that the number of pregnant women who had a dental visit during pregnancy increased by 13% from 2021.

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

Newborn hearing screening remained at above 95% for hospital discharged babies, but babies born in OI continued to miss out on this screening opportunity. Babies born in the Outer Islands who miss newborn hearing screening continued to prevent us from reaching 100% coverage on hearing screening for newborns.

MCH plans to conduct more outreach activities in the anticipated reporting year on early and adequate prenatal care services including gestational diabetes and infant anemia screening in the communities.

Perinatal/Infant Health Plan – FY 2024

The National Performance Measure (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. However, given that at least one NPM for each of the Population Domains, FSM anticipated to change NPM #3 to NPM 4B due to incapability of collecting data for NPM 3. FSM continue to collect data on very low birth-weight infants born in the Hospital; however, FSM does not provide services for LevelIII + Neonatal Intensive Care Unit, therefore, FSM MCH programs is not able to collect data for this partial measure. FSM is anticipating to track NPM 4 again for the remaining 2 years of the grant. FSM will continue to track partial data for NPM 3 as it was pre-selected in the 5-year needs assessment, and reported in the initial year.

Again, given that the NPM 3 does not really relate to the priority, as the priority is aiming at early and adequate prenatal care, State Performances are developed. 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 developed a second SPM 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. SPM #2. “Percent of pregnant women who are screened for gestational diabetes by 24-28 weeks”. Anemia Screening is not included in this SPM as it is already addressed in the Woman Health Domain.

FSM’s objective for SPM#1 is to increase the percent of pregnant women receiving prenatal services in the 1st trimester of pregnancy by 45% by end of 2024. Over the last 3 years Perinatal mortality was dropped as the data as depicted; from 48.9% in 2021 down to 23.9% in 2022. This strategy will not only target the pregnant women, 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. We hope to achieve this target by conducting at least 5 community awareness sessions (workshops, radio spots) on the importance of early pregnancy booking throughout the year. MCH is collaborating and partnering with other public health programs such as the Communicable Diseases Section, Behavioral Health and Wellness, Non-Communicable Diseases Section and the CHCs to serve the MCH Population.

The FSM MCH Program sets the target at 45% of pregnant women will be booked during their first trimester in 2023. 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 live births in the year

FSM’s objective for SPM#2 is to increase the percent of pregnant women screened for gestational diabetes by 45% by end of 2024. 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 / Total# of pregnant women during the year

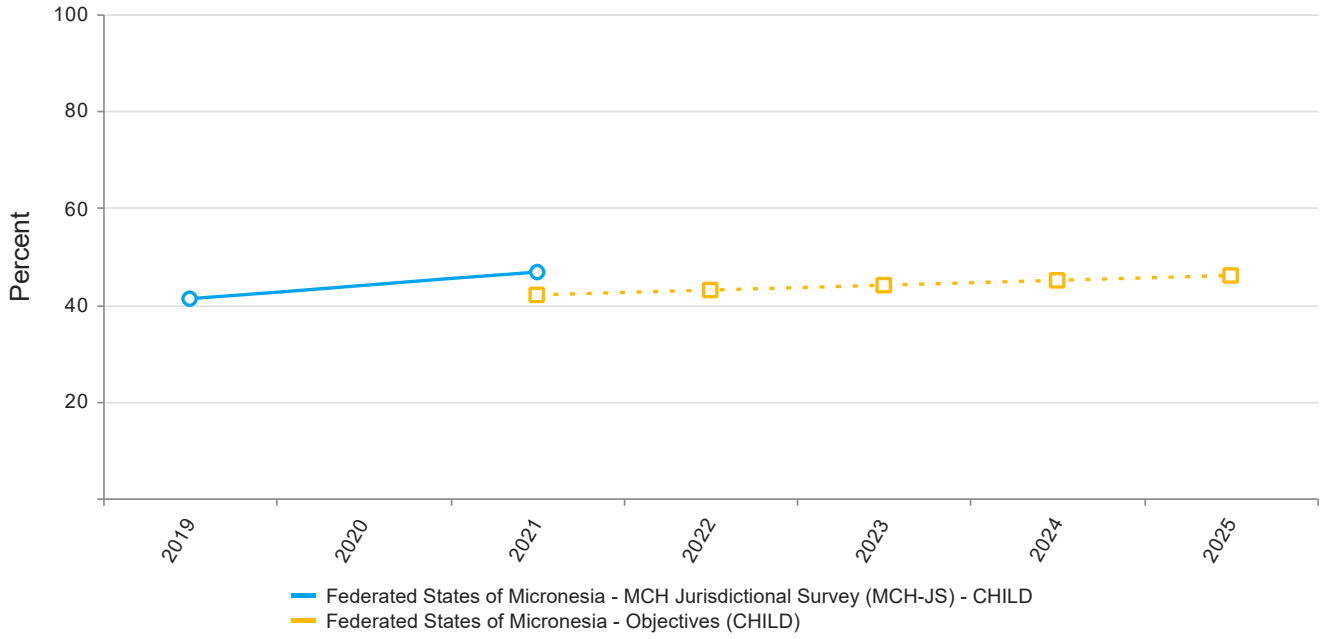
The MCH programs will ensure that the stated strategies are implemented successfully and that targets that are set in the objectives are met - these will ultimately improve the health and well-being of the Perinatal Population. Some of the FSM States have restarted their perinatal review committees but due to COVID19 pandemic prevention and containment efforts in the FSM, they find it to be not possible to continue with the activities. The FSM MCH Program will continue to push for revival and initiation of the perinatal committees in the States because there is evidence that their work helped and improved services in the OB clinic during the time when the committees were active.

2024 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 received early and adequate prenatal care services beginning during the first trimester including gestational diabetes screening by 24-28 weeks.	By 2024, increase the rate of pregnant women receiving prenatal services in the 1st trimester of pregnancy by 45%.	To conduct at least 5 community awareness sessions (workshops, radio spots) on the importance of early pregnancy booking	Number of pregnant women initiated prenatal care beginning during the first trimester/ Total live births
		By 2024, increase the percent of pregnant women screened for gestational diabetes by 45%	Ensuring inventory of GDM testing is adequate and that GDM is included in the Prenatal procedure and manual	Number of pregnant women screened for GDM by 24-28 weeks/ Total pregnant woman during the year.

Child Health

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**	**2021**	**2022**
Annual Objective			42	43
Annual Indicator	41.2	41.2	46.7	46.7
Numerator	2,724	2,724	5,624	5,624
Denominator	6,612	6,612	12,055	12,055
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			42	43
Annual Indicator				80.3
Numerator				14,023
Denominator				17,455
Data Source				Dept of Education
Data Source Year				2022
Provisional or Final ?				Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	44.0	45.0	46.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Percent of schools providing at least 60 minutes daily physical activity opportunities for students before, during and after school day.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			60	70
Annual Indicator			79.2	57.5
Numerator			10,793	107
Denominator			13,620	186
Data Source			FSM Data Matrix	FSM Data Matrix
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	80.0	85.0	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 minutes per day by 5% at the end of 2023	
Improve nutrition promotion and healthy weight among school children (6 – 11 years old) by 10% in 2023.	
Strategies	
To do Weight Contest among school children, 6-11 years old, in the schools.	
ESMs	**Status**
ESM 8.1.1 - Percent of schools providing at least 60 minutes daily physical activity opportunities for students before, during and after 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)	

Child Health

Priorities: Improving child health through healthy weight through physical activities and nutrition promotion

According to the school's data collected in each of the four FSM States, 76.3% of children ages 6 through 11 were physically active at least 60 minutes per day during school days in 2022. This is a 2.7 percent reduction from the previous year in 2021 of 79%. The objective of this priority is to increase the percentage of children who are screened, evaluated and counseled on BMI and physical activities during the reporting year.

Health screening in the schools have been part of MCH activities for years now. Past data collected in previous years from school health shows an increasing rate of obesity in children. Unfortunately, PE and health education are optional in some of the schools. Recess periods are mandatory in all schools for at least 30 minutes. In 2022 there were no major changes from the past year where 136 primary schools out of 186 schools in the FSM were visited for school health screening. In the State of Pohnpei, all elementary schools from 1st to 6th received sports balls (volleyball, soccer, and badminton) to support school PE programs and physical activities.

The MCH programs collaborate with the Department of Education on multiple activities in the schools. With this collaboration, School Health activities has always been supported by the Department of Education. Through this health screening, students are counseled on basic healthy eating habits, nutrition and physical exercises as well as hygiene practices. During the year, the School Health program was possible in some schools despite the situation with COVID19 vaccination activities.

All the schools are mandated to have a break time, and lunch break where students spend most of these periods playing actively, thus regarded as physically active. And there are no organized schools including afterschool programs and activities.

The school health screening shows increasing rates of obesity in school age children. People are relying more and more on store bought foods for their children, especially working parents. Most parents and caregivers tend to take the easy route and just buy sandwiches or burgers for their children's lunch. Sadly, it is becoming rare to see students with local food on their plates during lunch time. In some States, PE and Health Education are part of the curriculum, however, not all schools are offering these classes. They are not considered core classes at this time. Therefore, it is a little difficult to measure the percentage of students doing physical activities in the schools, but based on observation during school visits, more than 90% of students are actively playing during their break periods. Additionally, Most Health programs and schools does not have a nutritionist to assist in promotion of healthy diets and activities. It is also challenging to educate on nutrition promotion without the presence of a nutritionist. Nutrition counseling is mostly based on the basic knowledge of the nurses and physicians of the programs.

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.

Transportation issues continue to be unreliable and often dependent on availability of the ships or patrol boat to cover the vast number of outlying islands in the outer islands. 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 to implement the strategy for this domain. However, in Kosrae, implementing child health's strategy is not a problem because there is only one island, and the MCH programs has accessibility to the schools to implement activities pertaining to the child domain.

Child Health Plan – FY 2024

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 Physical Activity: Percentage of children ages 6 – 11 who are physically active for at least 60 minutes per day.

The objective for 2024 is to increase the percentage of children under 6 – 11 who are physically active for at least 60 min/day by 85%.

The FSM MCH Program plans to implement the only ESM in the 2024 action plan for the Child Health Domain:

1) Increase percentage of healthy children under 6 – 11 through physical activity at least 60 min/day by 85% at the end of 2024;

The strategy for objective #1 of the National Performance Measure 8.1 is to increase sports activities by providing sporting supplies and equipment to 1-6 graders in the schools.

The Evidenced-Based Strategic Measure (ESM) is Percent of children ages 6 – 11 years old doing school physical activity at least 60 minutes per day and is actually recorded in the physical activity attendance sheet. The numerator is "Number of 6 – 11 years old who are recorded in the school physical activity attendance sheet" and denominator is "total number of children ages 6 – 11 in the schools". 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 FSM MCH Program revised the 2023 action plan so it can also be used in 2024 based on the Reviewers comments and recommendations provided in the Summary Statement. The FSM MCH action plan for 2024, for the Child Health Domain, is being compiled not only to tackle the issue of obesity among the young children but it will also serve as a response that tie well into FSM fight against NCD as mandated in each State - the State of Emergency Declaration.

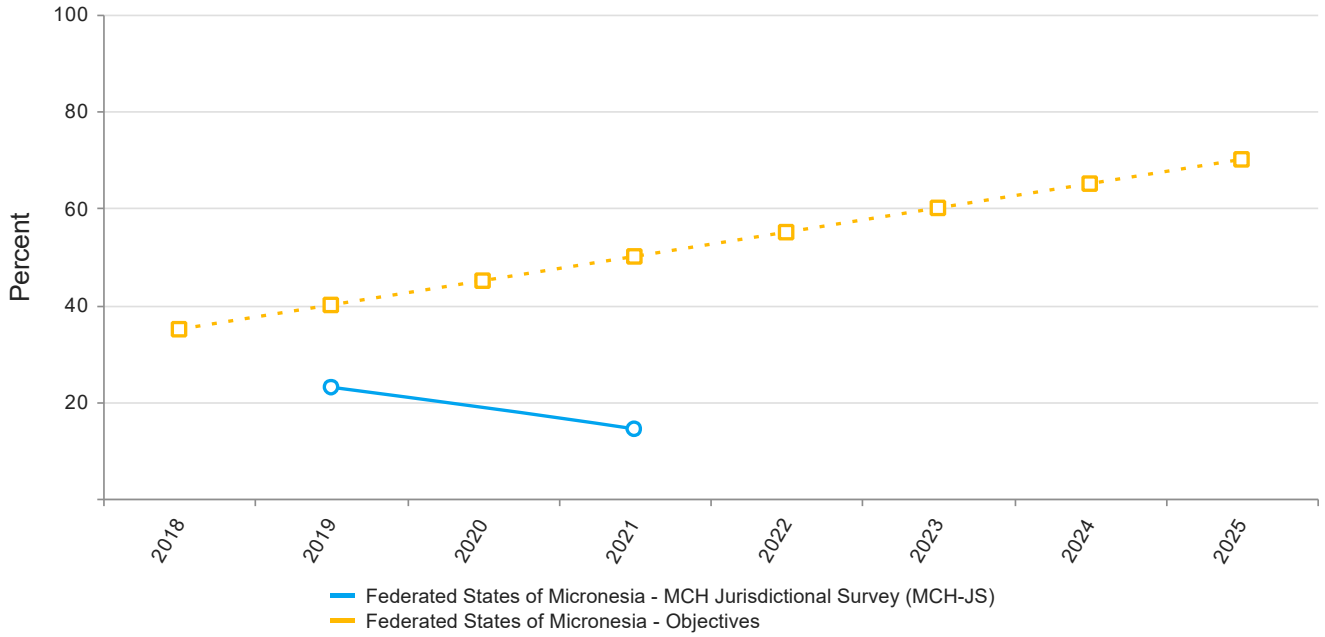
2024 FSM MCH ACTION PLAN					
Domain and State Priority Needs	**NATIONAL PERFORMANCE MEASURE**	**Objective**	**Strategies**	**ESM**	**Numerator/ Denominator**
Child Health					
Improve child health through healthy weight through physical activity and nutrition promotion	NPM 8.1 Percent of children, ages 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 85% at the end of 2024.	To increase sports activities by providing sporting supplies and equipment to 1-6 graders in the schools.	Percent of children ages 6 – 11 years old doing school physical activity at least 60 minutes per day and is actually recorded in the physical activity attendance sheet	Number of 6 – 11 years old who are recorded in the school physical activity attendance sheet Total number of 6 – 11 years old in the schools

There is still a scarcity of nutritionist on island, however, clinicians and health workers alike can aid in creating well-informed radio program or awareness campaign on good nutrition. The School Health Program visits all schools every year, clinicians or health workers who are more knowledgeable about nutrition accompany the program to provide education awareness on physical education and promote healthy nutrition simultaneously to children ages 6-11. Sources of data can be Department of Education (DOE), School Health and NCD Programs. DOE data can be obtained by reviewing primary school curriculum or via active collection by visiting or calling each school directly. The MCH staff accompanying the School Health Program and NCD program during primary outreach activities can also siege the opportunity and use the time to collect much needed information including data.

Adolescent Health

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**	**2021**	**2022**
Annual Objective	40	45	50	55
Annual Indicator	23.2	23.2	14.5	14.5
Numerator	1,680	1,680	1,660	1,660
Denominator	7,251	7,251	11,431	11,431
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	35	40	45	50	55
Annual Indicator	0	23.2			79.9
Numerator	0	1,680			6,826
Denominator	100	7,251			8,547
Data Source	-- State --	State			MCH Program
Data Source Year	-- State	State			2022
Provisional or Final ?	Provisional	Provisional			Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	60.0	65.0	70.0

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					
	2018	2019	2020	2021	2022
Annual Objective		35	38	40	20
Annual Indicator		61.5	78.3	15.4	24
Numerator		99	137	1,195	3,828
Denominator		161	175	7,770	15,925
Data Source		MCH program and Education	MCH program and Education	FSM Data Matrix	FSM Data Matrix
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	40.0	70.0

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

State Provided Data			
	2020	2021	2022
Annual Objective			10
Annual Indicator		6.7	24
Numerator		1,336	3,828
Denominator		19,929	15,925
Data Source		FSM Data Matrix	Public Health and Census
Data Source Year		2021	2022
Provisional or Final ?		Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	40.0	60.0

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 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 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

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 2023, 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

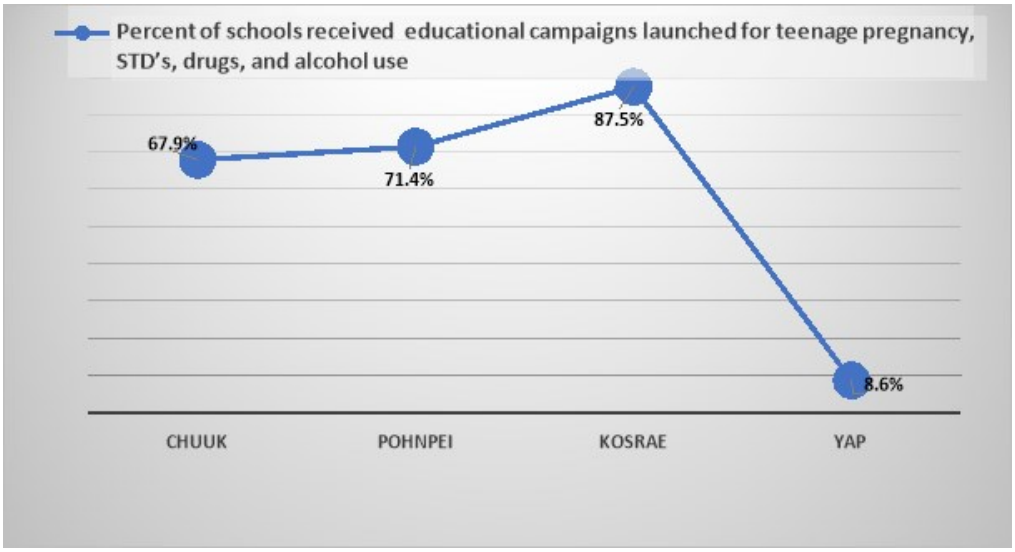
Provide educational awareness in the schools on preventive medical visits.

Adolescent Health

Priority: Improving adolescent health by providing well medical visits, assessing violence and safety, and promoting healthy behaviors and reducing risks

The teen birth rate (15-19 years old) is slightly dropped from 42.6/1,000 births in 2021 to 41.8 births per 1,000 in 2022. The NPM 10 was selected for this domain: Percent of adolescents ages 12 through 17 attending educational awareness on preventive medical visits in the schools. The FSM objective in 2022 is to increase the percent of adolescents that received a well adolescent visit by providing training to health care providers on professional development training who report skills in effectively counseling youth on changing risky behaviors.

Beside the close down of borders during Covid 19 pandemic, several MCH activities were canceled due to re-shuffling of health staffs for Covid-19 activities. High-risk of 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. Overall, the objective for this domain was partially met in 2022.



Adolescents are encouraged to walk in anytime to the health centers if needed. There are no specific or assigned clinics for this population, as all the needed services are integrated into all the PH programs, dispensaries and CHC clinics to be able to render the needed services discreetly to this population. Referrals amongst the programs are made when they see fit to best address the health needs of these youths once one presents to any of the clinics. It has always been successful. Further, through the PREP program and collaboration with other programs like Family Planning and BHW, school visits and education awareness on all the youth risky behaviors were made possible during the year. About 15 percent of the youths in the FSM received some kind of well medical visits through clinic visits, school awareness programs, and medical clearance for college entry.

The MCH Program is currently working with youth groups and other affiliated agencies 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.

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 - Application Year

Adolescent Health Plan – FY 2024

The priority for the Adolescent Health Domain is to improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors and reducing risk behaviors (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide). The selected NPM for this priority is NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. The strategy for this NPM is to "provide educational awareness in the schools on preventive medical visits" and the ESM for this strategy is "Percent of adolescents ages 12 through 17 attending educational awareness sessions in the schools who actually visited the clinics for a preventive medical service. Again, medical visit is a broad area of health service and FSM finds it to be difficult to track, collect data and report on. Therefore, the MCH Program decided to develop a proxy measure around assessing violence and safety and promoting healthy adolescent behaviors & reducing risk behaviors and poor outcomes. As a result, a State Performance Measure was developed. The new SPM under this domain is "percent of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools" and the objective is "by 2024, increase the percentage of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools that actually received a well-adolescent visit by 35%. The strategy for the SPM "is to provide educational awareness in all the schools on the importance of well medical check-ups or health preventive visits". This is needed so that students are able to make wise decisions and are 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. The numerator is the "number of 12-17 years old attended education on adolescent's health during the past school year who actually visited the clinics for a preventive medical service" and the denominator is the "number of 12-17 years old in the schools who attended educational awareness sessions in the schools on the importance of well medical check-ups or health preventive visits". The MCH Program will continue to work closely with PREP, BH&W and other public health programs, Dept. of Education and other partners to promote healthy behaviors and reduce risk behaviors for adolescent in all the schools in FSM.

The FSM MCH and Family Planning Programs will continue to work closely with the school administrators in the states to incorporate the sexuality and family life education into their school curriculum. The sexuality and family life education are one of the many activities/initiatives targeting in-school adolescents which is funded by the United Nations Population Fund (UNFPA) as part of their program of assistance to the government of FSM. This initiative is made specifically to prevent the high rate of teen pregnancy by propagating healthy lifestyles. During the past years, the age of consent in the FSM was 13 years old. With the support of the other public health programs and agencies that we work or partner with, laws on age of consent have been amended increasing age of consent 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, youths will receive information and education on risky behaviors and its possible negative outcomes as well as healthy behaviors.

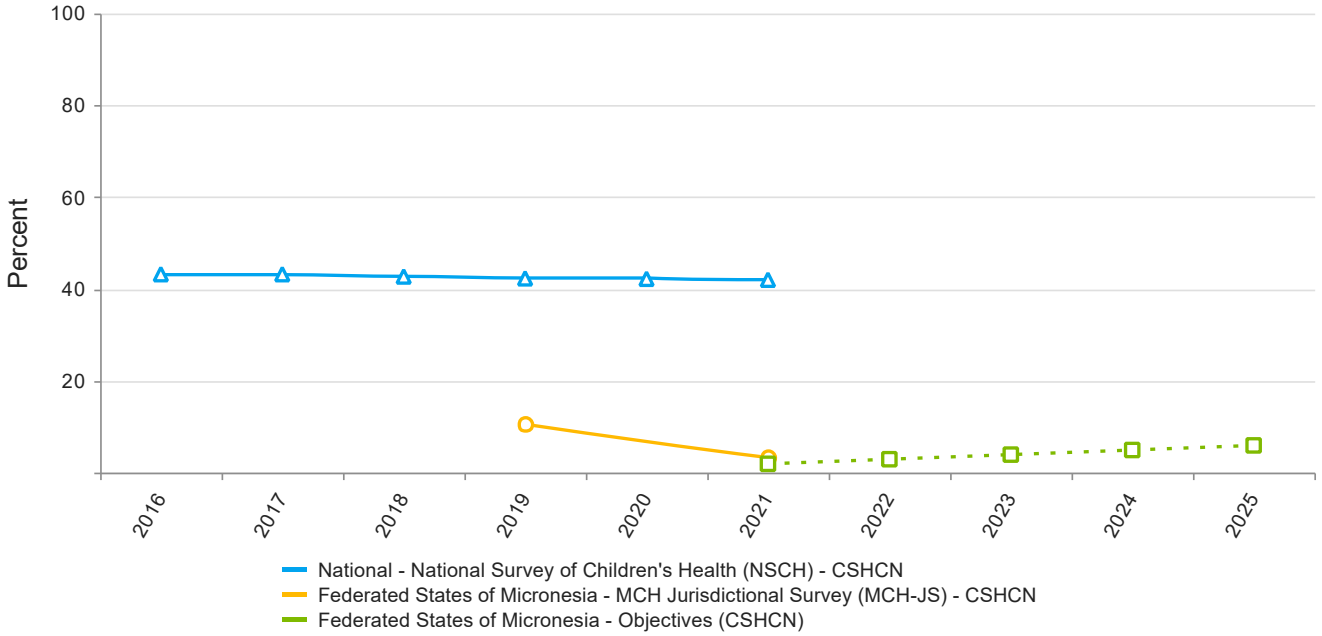
2024 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerator/ Denominator**
Adolescent Health				
Improve adolescent health by providing well medical visits, assessing violence and safety and promoting healthy adolescent behaviors 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 2024, increase the percentage of adolescents aged 12-17 years who have attended educational awareness sessions on adolescent and behavioral health in the schools that actually received a well-adolescent visit by 35%.	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 who actually visited the clinics for a preventive medical service
				Number of 12-17 years old in the schools who attended educational awareness sessions in the schools on the importance of well medical check-ups or health preventive visits

Children with Special Health Care Needs

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**	**2021**	**2022**
Annual Objective			2	3
Annual Indicator	10.4	10.4	3.2	3.2
Numerator	167	167	73	73
Denominator	1,607	1,607	2,245	2,245
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021

State Provided Data				
	2019	2020	2021	2022
Annual Objective			2	3
Annual Indicator				92.4
Numerator				2,352
Denominator				2,545
Data Source				CSHCN program
Data Source Year				2022
Provisional or Final ?				Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	4.0	5.0	6.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CSHCN providers received specialty training from overseas consultants

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective				90
Annual Indicator			97.1	30.9
Numerator			1,518	17
Denominator			1,563	55
Data Source			FSM Data Matrix	FSM Data Matrix
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	50.0	60.0

State Performance Measures

SPM 5 - Percent of parents/caregivers receiving components of the medical home training

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	10
Annual Indicator			80	30.9
Numerator			44	17
Denominator			55	55
Data Source			FSM Data Matrix	CSHCN program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	50.0	60.0

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 received specialty training from overseas consultants	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 components of the medical home training

Objectives

By 2023, increase percent of Children with special health care needs, ages 0 through 17, with a medical home by 5%.

By December 2023, increase the percent of parents/caregivers receiving specialty trainings in care coordination of CSHCN by 5%.

Strategies

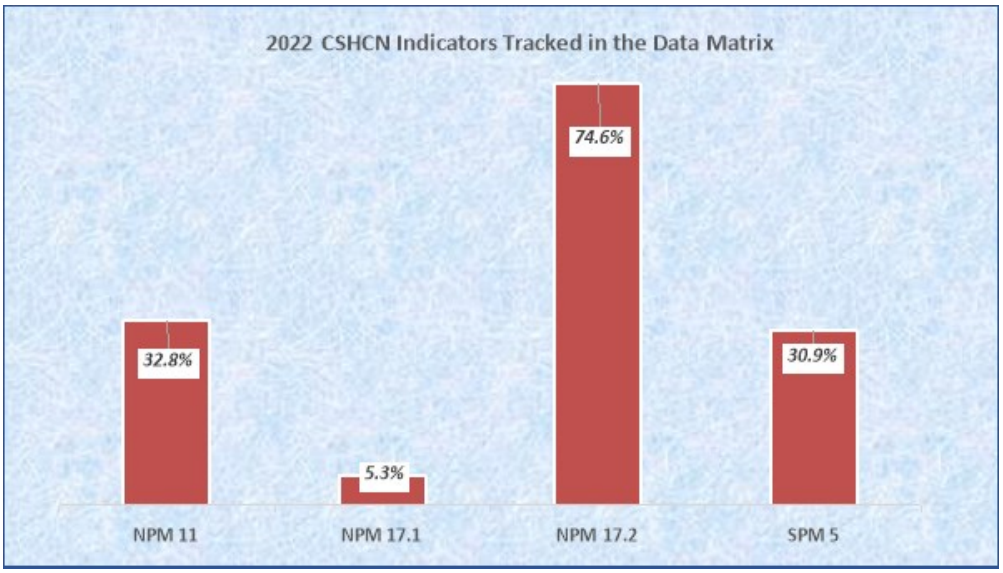
Work with experts/specialists to provide specialty training to providers and parents/caregivers on complete component of a medical home.

Work collaboratively with specialist/specialized trainers to provide more and continuous Care Coordination Training to CSHCN parents/caregivers in the FSM States.

Children with Special Health Care Needs (CSHCN)

Priority: Provide Care Coordination training for parents/caregivers of Children with Special Health Care Needs

The 2022 SPM for this domain is Percent of parents/caregivers receiving training on specialty care for children with special health care needs (CSHCN). The objective for this domain is to increase the percentage of parents/caregivers receiving specialty trainings on CSHCN care coordination. The strategy for this SPM is to work collaboratively with specializing trainers to provide training to CSHCN parents/caregivers in the States The percent of providers receiving training on specialty care for receiving trainings on CSHCN for care coordination in the past year is 30.9.



According to the FSM MCH Data matrix, 2,232 children 0-17 are registered in the CSHCN registry as of 2022. Similar to previous years, CSHN Program does not have an assigned Physician to oversee leaving the program back to square one. Any available physician sees CSHN clients as outpatient basis only. The state Public health clinics and main island dispensaries, Community Health Centers, and outer island dispensaries are regarded as medical homes for our clients. EHDI parent group and individual family's consultation were the only conducted training during the year.

All the Public health sites, dispensaries and CHC sites are considered medical homes for the CSHN clients. They are being used by the clients and families in their respective areas. With the collaboration with SPED and CHC, CSHN clients are either seen at the DHS or CHC for their medical follow up. Also, due to the restrictions on social gathering and lessening the exposure of our vulnerable clients to the crowded areas such as the health services clinics, MCH started doing home visits with SPED. Home visits are coordinated with SPED to avoid multiple visits during this COVID19 pandemic. MCH and SPED share working templates or Care Plans for the individual clients based on their specific disability needs, as recommended by the physician who was designated for CSHN clients and families during the year. Through the EHDI Program, a parent's group was created with a parent leader. This group had meetings and training with the assistance of Dr. Camacho (Speech Pathologist) and Dr. Koffend (Audiologist). Parent leader and CSHN did home follow up with the client in the absence of group meetings every three months.

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 1,600 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 2021 was set at 15%. However, only 1.5% of adolescents with and

without special health care needs received CSHCN services and have a medical home.

Besides the EHDI parent meetings and training, other training for all parents and caregivers during the year were not possible due to the pandemic. The only training the program had was with the EHDI parent group, but this was limited to only families with hearing disability. Other families were individually consulted, with the involvement of the physician, and SPED folks for overall management of each individual client care. Each year, a different physician is assigned to oversee CSHN clinics, based on their availability of not being tasked to oversee other clinics. Sometimes appointments were canceled due to the lack of a physician, which was so common during the year due to the pandemic. This has been a long-standing problem for the FSM states.

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. 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 continued to work remotely with the EHDI consultants to screen children with hearing development and issues.

Children with Special Health Care Needs (CSHCN) Plan – FY 2024

In the four states, an interagency agreement for the CSHCN Program has been developed that involves the MCH/CSHCN Program, the State Hospitals, 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 Special Education Program/Early Intervention Service, is an essential partner of the MCH/CSHCN Program. Most of the CSHCNs who were referred by the Special Education Program, were picked up through their Annual Child-Find Activities. This is part of the collaborative work that the Special Education Program does with the MCH/CSHCN Program to identify those children suspected of having special health conditions for diagnosis and early intervention services. FSM lacks experts or specialists who can provide specialty care for CSHCNs therefore the Special Education and the MCH Programs also seek for specialists to provide specialty training for providers, parents and caregivers so they enhance their skills and knowledge to better serve those children with special health care needs. It is also the goal of the MCH program that the specialty trainings increase and are continuous for providers and facilities providing CSHCN services to families and CSHCN clients.

Based on the Summary Review, FSM decided to edit or revise the MCH action plan for 2023 and implement the revised plan in 2024. The priority of the MCH Program is to provide care coordination training for parents and or caregivers of children with Special Health Care Needs. Since grantees are required to select one NPM for each domain, FSM selected NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home. Our strategy for this NPM is to “work with experts/specialists to provide specialized training to providers and parents/caregivers on complete component of a medical home”. Considering that “Medical Home” is defined or construed quite differently in the FSM, it would be difficult for us to track, collect and report data for Medical Home. For this reason, FSM developed a SPM - Percent of parents/caregivers received and completed training in Care Coordination of services for children with special health care needs (CSHCN). Our objective is “by December 2024, increase the percentage of parents/caregivers receiving specialty trainings in Care Coordination of services for CSHCN by 50%”. Our strategy is to “work collaboratively with specialist/specialized trainers to provide more and continuous Care Coordination training to CSHCN parents/caregivers in the FSM States”. Our numerator is the number of parents/caregivers receiving training on care coordination for CSHCNs and denominator is the total number of parents/care givers during the reporting year. In 2022, number of children ages 0-17 who were registered in the FSM CSHCN registry increased to 2232.

2024 FSM MCH ACTION PLAN				
Domain and State Priority Needs	**STATE PERFORMANCE MEASURE**	**Objective**	**SPM Strategies**	**Numerator/ Denominator**
Children with Special Health Care Needs				
Provide care coordination training for parents/caregivers of Children with Special Health Care Needs	Percent of parents/caregivers received and completed training in Care Coordination of services for children with special health care needs (CSHCN)	By December 2024, increase the percentage of parents /caregivers receiving specialty trainings in care coordination of services for CSHCNs by 50%.	Work collaboratively with specialists/ specialized trainers to provide more and continuous care coordination training to CSHCN parents/caregivers in the FSM States.	Number of parents/caregivers receiving trainings on care coordination for CSHCN Total number of parents/caregivers during the reporting year

Cross Cutting

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 needs assessment 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 children with special healthcare needs, and about one-third believe it is a concern for children. Unfortunately, behavioral/mental health treatment services are lacking in the FSM.

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.

In 2021, the FSM MCH Program plans to support practices with technical assistance to develop and implement behavioral health, substance use disorders, trauma, depression and interpersonal violence screening. This strategy will be measured by the number of providers and facilities receiving technical assistance about behavioral health screening. If the strategy is successfully implemented screening will be added for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues during well women, well adolescent and prenatal care visits as evidenced by the addition to all 3 visits documentation. In addition to improving screening and treatment for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues, we also anticipate improvements on key national outcome measures such as percent of children in excellent or very good health, rate of severe maternal morbidity per 10,000 delivery hospitalizations, maternal mortality rate per 100,000 live births, percent of low birth weight deliveries (<2,500 grams), percent of very low birth weight deliveries (<1,500 grams), etc. Detailed action plan for the coming year is as follow:

DOMAIN: Cross Cutting

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

SPM #1: Percent of adolescents and women screened for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues

Objectives	Strategies	Evidence–Based Strategy Measures	National and State Outcome Measures
By 2021, add screening for behavioral health, substance use disorders, trauma,	Support practices with technical assistance to develop and implement behavioral health, substance use disorders, trauma, depression and interpersonal violence screening	# of providers and facilities receiving technical assistance about behavioral health screening	NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months NOM 19 - Percent of children in excellent or very good health NOM 2 - Rate of severe

DOMAIN: Cross Cutting

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

SPM #1: Percent of adolescents and women screened for behavioral health, substance use disorders, trauma, depression and interpersonal violence issues

Objectives	Strategies	Evidence–Based Strategy Measures	National and State Outcome Measures
depression and interpersonal violence issues during well women, well adolescent and prenatal care visits as evidenced by the addition to all 3 visits documentation.			maternal morbidity per 10,000 delivery hospitalizations NOM 3 - Maternal mortality rate per 100,000 live births NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams) NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams) NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams) NOM 5.1 - Percent of preterm births (<37 weeks) NOM 5.2 - Percent of early preterm births (<34 weeks) NOM 5.3 - Percent of late preterm births (34-36 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

Progress: FSM recognizes that substance use disorders, trauma, depression and interpersonal violence issues do exist within our service population, however, the MCH Program relies on our internal partnership with the FSM and

States Behavioral Health Programs to spearhead the intervention activities and services necessary to respond to this priority. It was reported by the Manager of the Behavioral Health Unit that they did limited counseling training sessions at the state level so some degree of intervention can be provided. FSM Behavioral Health Unit hired a Psychiatrist from Fiji who coordinated and provided the counseling sessions. He also traveled to the FSM states doing education, counseling trainings as well as direct patient behavioral consultation. The Covid-19 was the major challenge to implementation of the activities under this domain and we hope to increase our services since the Covid-19 has passed us.

Cross cutting

FSM does not plan to implement any activity under this domain in 2024.

III.F. Public Input

Public Input

The FSM MCH Program, desires to revamp and diversify its Public Input Strategies. The MCH Program plans to continue to hold workshops to provide an open and collaborative approach with various agencies, community advisory board members, parent advisory panel members, families, and other stakeholders to facilitate public input. The program, however is revamping and expanding the public input process to also include public web postings on social media sites, and outreach through emails to stakeholders and partners.

Copies of the Program Overview for the 2024 MCH Block Grant application was provided, as email attachment, to the management of the National and State Departments of Health Services for their review and comment. The management team at the National Health department included the Secretary, Assistant Secretary for Health, and Program Managers for the six (6) Units within the Division of Health Services. They included Communicable Diseases Unit, Non-Communicable Diseases Unit, Behavioral Health and Wellness Unit, Immunization Unit, and Food Safety and Environmental Health Unit. The management team at the State Health department included the Directors, Chiefs of Public Health and state MCH Program Coordinators.

The MCH Program hopes to receive feedbacks from the other members of the National and State Health Departments' leadership in time and before the 2023 block grant reviews on September 12, 2023.

The FSM Title V Program will post copy of the 2022 Annual Report/2024 Application on the FSM Public Information Office (PIO) Website for partners, stakeholders, and the FSM States community as part of the public input process. Comments were encouraged through emails directly to the Family Health Services Unit Program Manager / National MCH Program Coordinator, social media platforms, and through phone via contact with the FSM Department of Health and Social Affairs, Family Health Services Unit, MCH Program. The comments and or feedbacks from the public are anticipated to be received before August 31, 2023.

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.

In light of our priorities and the activities we have identified for the upcoming year, the FSM State MCH program is anticipated to submit TA requests to support our work in 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 screenings in the dispensaries on the main islands and dispensaries on the outer islands to reduce health disparity.
3. TA on the alignment of the NPMs, SPMs, ESMs and Strategies.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - 2020-2022 FSM MCH Data Matrix.pdf

Supporting Document #02 - FSM Family health TELEHEALTH PROJECT.pdf

Supporting Document #03 - Resume.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - DHSA Official Organizational Chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Federated States of Micronesia

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 528,967	
A. Preventive and Primary Care for Children	$ 159,219	(30%)
B. Children with Special Health Care Needs	$ 168,212	(31.8%)
C. Title V Administrative Costs	$ 52,896	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 380,327	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 110,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 440,000	
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)	$ 550,000	
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)	$ 1,078,967	
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)	$ 703,300	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 1,782,267	

OTHER FEDERAL FUNDS	FY 24 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) > Office of Population Affairs (OPA) > Title X Family Planning	$ 368,300
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 519,806 (FY 22 Federal Award: $ 528,967)		$ 523,967	
A. Preventive and Primary Care for Children	$ 159,580	(30.7%)	$ 159,580	(30.4%)
B. Children with Special Health Care Needs	$ 165,298	(31.8%)	$ 165,298	(31.5%)
C. Title V Administrative Costs	$ 47,302	(9.1%)	$ 47,302	(9.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 372,180		$ 372,180	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 115,000		$ 110,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 816,225		$ 816,225	
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)	$ 931,225		$ 926,225	
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		$ 1,450,192	
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		$ 653,300	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 2,104,331		$ 2,103,492	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000	$ 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	$ 368,300	$ 368,300

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 71,190	$ 53,432
2. Infants < 1 year	$ 72,790	$ 96,700
3. Children 1 through 21 Years	$ 159,219	$ 159,580
4. CSHCN	$ 168,212	$ 165,298
5. All Others	$ 4,660	$ 1,655
Federal Total of Individuals Served	$ 476,071	$ 476,665

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 102,000	$ 102,000
2. Infants < 1 year	$ 120,740	$ 120,740
3. Children 1 through 21 Years	$ 97,600	$ 97,600
4. CSHCN	$ 115,000	$ 115,000
5. All Others	$ 4,660	$ 4,660
Non-Federal Total of Individuals Served	$ 440,000	$ 440,000
Federal State MCH Block Grant Partnership Total	$ 916,071	$ 916,665

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

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 24 Application Budgeted	FY 22 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	$ 274,485	$ 270,485
3. Public Health Services and Systems	$ 254,482	$ 253,482
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	$ 528,967	$ 523,967

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 276,890	$ 440,000
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 85,150	$ 191,510
B. Preventive and Primary Care Services for Children	$ 90,740	$ 138,420
C. Services for CSHCN	$ 101,000	$ 110,070
2. Enabling Services	$ 50,110	$ 0
3. Public Health Services and Systems	$ 113,000	$ 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		$ 62,000
Physician/Office Services		$ 98,000
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 51,000
Dental Care (Does Not Include Orthodontic Services)		$ 75,000
Durable Medical Equipment and Supplies		$ 75,170
Laboratory Services		$ 78,830
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: 1,531 **Data Source Year: 2022**

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	1,122 (73.3%)	2	2	2 (100.0%)

Program Name(s)
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
CSHCN-Rheumatic Fever	496	192	192	192

4. Long-Term Follow-Up

Infants with failed hearing screening have to go through evaluation and treatment. The duration of treatment is based on the doctor's recommendation.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

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 2022

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	1,600	0.0	0.0	0.0	100.0	0.0
2. Infants < 1 Year of Age	1,612	0.0	0.0	0.0	100.0	0.0
3. Children 1 through 21 Years of Age	28,040	0.0	0.0	0.0	100.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,563	0.0	0.0	0.0	100.0	0.0
4. Others	10,000	0.0	0.0	0.0	100.0	0.0
Total	41,252					

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	1,896	Yes	1,896	94.0	1,782	1,600
2. Infants < 1 Year of Age	1,857	Yes	1,857	97.0	1,801	1,612
3. Children 1 through 21 Years of Age	40,554	Yes	40,554	85.0	34,471	28,040
3a. Children with Special Health Care Needs 0 through 21 years of age^	2,629	Yes	2,629	75.0	1,972	1,563
4. Others	59,264	Yes	59,264	20.0	11,853	10,000

^Represents a subset of all infants and children.

Form Notes for Form 5:

Title V funds provide enabling services, Public health services and Systems. By providing preventive screenings for pregnant women (anemia & cervical), STI screenings. Community Outreach activities to the MCH population domains. Also, expanding and developing MCH data collection web-based systems.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: Pregnant women were recorded and reported when visited MCH clinics.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: Data is reported from Public Health Administration records.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: 2020 Census data was use as denominator for this measure.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Actual CSHCN data records was reported for this indicator.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: Estimated population for others who received MCH services.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2022**
	Field Note: Estimated total number of people received MCH services in the FSM.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: Data is under-reported as outer island pregnant women were not reported.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Outer islands infants were not reported in this data.	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: This indicator is under-reported as many children receiving MCH services were not recorded during outreaches in the communities.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Services for actual registered CSHCN clients are under-reported in 2022.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Less than 21% of other population group is receiving MCH services in the FSM.	

Data Alerts: None

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

State: Federated States of Micronesia

Annual Report Year 2022

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	1,531	0	0	0	0	0	1,531	0	0
Title V Served	1,531	0	0	0	0	0	1,531	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0
2. Total Infants in State	1,612	0	0	0	0	0	1,612	0	0
Title V Served	1,612	0	0	0	0	0	1,612	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

FSM does not have Title XIX funding.

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	2024 Application Year	2022 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	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	N/A	N/A
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	health@fsmhealth.fm	health@fsmheatlth.fm
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	N/A	N/A
6. Number of Hits to the State Title V Program Social Media Websites		0

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	Family Health Program Manager
Address 1	PS 70
Address 2	
City/State/Zip	Plaikir / FM / 96941
Telephone	(691) 320-2619
Extension	
Email	desaimon@fsmhealth.fm

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Dionisio Saimon
Title	Family Health Program Manager
Address 1	PS 70
Address 2	
City/State/Zip	Palikir / FM / 96941
Telephone	(691) 320-2619
Extension	
Email	desaimon@fsmhealth.fm

3. State Family Leader (Optional)	
Name	Arlynn Linny
Title	System Manager
Address 1	PS 70
Address 2	
City/State/Zip	Pohnpei / FM / 96941
Telephone	(691) 320-2619
Extension	
Email	arlinny@fsmhealth.fm

4. State Youth Leader (Optional)	
Name	Stanley Mickey
Title	Family Planning Coordinator
Address 1	PS 70
Address 2	
City/State/Zip	Pohnpei / FM / 96941
Telephone	(691) 320-2619
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 2024

No.	Priority Need
1.	Access to health services- Improve women's health through cervical cancer and anemia screening
2.	Improve perinatal/infant outcomes through early and adequate prenatal care services including Gestational Diabetes and anemia screening and promoting breastfeeding
3.	Improve child health through healthy weight through physical activity and nutrition promotion
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
5.	Provide care coordination training for parents/caregivers of Children with Special Health Care Needs
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.
7.	Improve health promotion communication

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 2

Field Note:
In 2023, FSM MCH program would like to track NPM 4b- Percent of infants breastfed exclusively through 6 months.

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 10
National Outcome Measures (NOMs)

State: Federated States of Micronesia

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

MCH data shown are only for pregnant women who received prenatal care in 1st trimester at the Public Health clinics; private clinics were not included in the count.

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	
	2022
Annual Indicator	15.7
Numerator	264
Denominator	1,677
Data Source	MCH program and Vital statistics
Data Source Year	2022

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.

State Provided Data	
	2022
Annual Indicator	22.3
Numerator	3
Denominator	1,348
Data Source	Vital Statistics
Data Source Year	2022

NOM 2 - Notes:

None

Data Alerts: None

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

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
2021	11.1 %	2.0 %	4,039	36,336
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	
	2022
Annual Indicator	4.0
Numerator	67
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

NOM 4 - Notes:

None

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
2021	15.6 %	2.8 %	5,666	36,336
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	
	2022
Annual Indicator	2.6
Numerator	43
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

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	
	2022
Annual Indicator	6.1
Numerator	102
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

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:

None

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	
	2022
Annual Indicator	23.9
Numerator	41
Denominator	1,717
Data Source	Vital statistics
Data Source Year	2022

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**
2021	21.0		49	
2020	20.9		54	
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	
	2022
Annual Indicator	16.7
Numerator	28
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

NOM 9.1 - Notes:

None

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**
2021	12.9		31	
2020	12.9		34	
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	
	2022
Annual Indicator	12.5
Numerator	21
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

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	
	2022
Annual Indicator	4.2
Numerator	7
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

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	
	2022
Annual Indicator	417.4
Numerator	7
Denominator	1,677
Data Source	Vital statistics
Data Source Year	2022

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.

State Provided Data	
	2022
Annual Indicator	1.0
Numerator	1
Denominator	100,000
Data Source	none
Data Source Year	none

NOM 9.5 - Notes:

FSM does not track and report this measure.

Data Alerts: None

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.

State Provided Data	
	2022
Annual Indicator	1.0
Numerator	1
Denominator	100
Data Source	none
Data Source Year	none

NOM 10 - Notes:

FSM does not track nor report this measure.

Data Alerts: None

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

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

State Provided Data	
	2022
Annual Indicator	1.0
Numerator	1
Denominator	1,000
Data Source	none
Data Source Year	none

NOM 11 - Notes:

FSM does not track nor report this indicator. No expertise to do the work.

Data Alerts: None

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
2021	16.0 %	2.2 %	5,478	34,248
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

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	
	2022
Annual Indicator	30.9
Numerator	7
Denominator	22,629
Data Source	Vital statistics and Census
Data Source Year	2020 2022

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	
	2022
Annual Indicator	29.1
Numerator	7
Denominator	24,016
Data Source	Vital statistics and 2020 Census
Data Source Year	2022

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	
	2022
Annual Indicator	1.0
Numerator	1
Denominator	100,000
Data Source	Vital statistics
Data Source Year	2022

NOM 16.2 - Notes:

There were zero adolescent motor vehicles in 2022.

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	
	2022
Annual Indicator	8.4
Numerator	1
Denominator	11,940
Data Source	Vital statistics and 2020 Census
Data Source Year	2022

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**
2021	6.2 %	1.7 %	2,245	36,336
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	
	2022
Annual Indicator	5.3
Numerator	2,232
Denominator	42,079
Data Source	CSHCN program and 2020 Census data
Data Source Year	2022

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
2021	0 %	0	0	2,245
2019	0 %	0	0	1,607

Legends:

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

State Provided Data

	2022
Annual Indicator	65.5
Numerator	1,666
Denominator	2,545
Data Source	CSHCN and 2020 Census
Data Source Year	2022

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
2021	0.6 %	0.4 %	180	30,210
2019	0.2 %	0.2 %	32	17,039

Legends:

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

State Provided Data	
	2022
Annual Indicator	0.1
Numerator	43
Denominator	30,870
Data Source	CSHCN and 2020 Census
Data Source Year	2022

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
2021	0.4 %	0.3 %	125	30,210
2019	0.5 %	0.4 %	84	17,039

Legends:

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

State Provided Data

	2022
Annual Indicator	0.1
Numerator	30
Denominator	30,870
Data Source	CSHCN and 2020 Census
Data Source Year	2022

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**
2021	0 %	0	0	1,171
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	
	2022
Annual Indicator	1.1
Numerator	17
Denominator	1,486
Data Source	CSHCN and 2020 Census
Data Source Year	2022

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**
2021	83.4 %	2.4 %	30,312	36,336
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	
	2022
Annual Indicator	16.5
Numerator	7,061
Denominator	42,915
Data Source	MCH PRogram and 2020 Census
Data Source Year	2022

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
2021	18.0 %	3.6 %	2,988	16,574
2019	27.5 % ϟ	5.4 % ϟ	2,632 ϟ	9,560 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	
	2022
Annual Indicator	3.5
Numerator	465
Denominator	13,396
Data Source	MCH Program and 2020 Census
Data Source Year	2022

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**
2021	68.7 %	2.6 %	24,952	36,336
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	
	2022
Annual Indicator	32.3
Numerator	13,843
Denominator	42,915
Data Source	Micare and 2020 Census
Data Source Year	2022

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	
	2022
Annual Indicator	70.6
Numerator	3,283
Denominator	4,647
Data Source	Immunization WebIZ
Data Source Year	2022

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	
	2022
Annual Indicator	42.1
Numerator	15,870
Denominator	37,655
Data Source	Immunization WebIZ
Data Source Year	2022

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	
	2022
Annual Indicator	20.6
Numerator	1,031
Denominator	5,004
Data Source	Immunization WebIZ and 2020 Census
Data Source Year	2022

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	
	2022
Annual Indicator	32.9
Numerator	3,788
Denominator	11,524
Data Source	Immunization Weblz and 2020 Census
Data Source Year	2022

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.

State Provided Data	
	2022
Annual Indicator	1.0
Numerator	1
Denominator	100
Data Source	MCH Data matrix
Data Source Year	2022

NOM 22.5 - Notes:

FSM does not have meningococcal conjugate vaccine.

Data Alerts: None

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**
2020	11.8			
2019	12.5			
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	
	2022
Annual Indicator	25.8
Numerator	149
Denominator	5,783
Data Source	MCH Program and 2020 Census
Data Source Year	2022

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	
	2022
Annual Indicator	1.0
Numerator	1
Denominator	100
Data Source	MCH Program
Data Source Year	2022

NOM 24 - Notes:

FSM does not provide service to women who experience postpartum depressive symptoms due to lack of expertise in this field.

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**
2021	2.6 % ϟ	1.0 % ϟ	963 ϟ	36,336 ϟ
2019	8.5 %	2.4 %	1,756	20,558

Legends:

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

State Provided Data	
	2022
Annual Indicator	3.0
Numerator	1,283
Denominator	42,915
Data Source	MCH Program and 2020 Census
Data Source Year	2022

NOM 25 - Notes:

Kosrae and Pohnpei does not report data on this indicator

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**	**2021**	**2022**
Annual Objective		85	50	42
Annual Indicator	57.8	57.8	39.4	39.4
Numerator	9,102	9,102	10,553	10,553
Denominator	15,758	15,758	26,751	26,751
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	78	80	85	50	42
Annual Indicator	73.8	57.8	43.9	39.4	11.2
Numerator	7,074	9,102	3,046	10,553	2,068
Denominator	9,589	15,758	6,940	26,751	18,428
Data Source	MCH Program	MCH Program	MCH Program	MCH-JS	MCH Program
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	20.0	35.0	65.0

Field Level Notes for Form 10 NPMs:

1.	**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 4A - Percent of infants who are ever breastfed

Federally Available Data	
Data Source: MCH Jurisdictional Survey (MCH-JS)	
	2022
Annual Objective	
Annual Indicator	84.5
Numerator	10,853
Denominator	12,850
Data Source	MCH-JS
Data Source Year	2021

Annual Objectives		
	2024	**2025**
Annual Objective	90.0	95.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data	
	2022
Annual Objective	
Annual Indicator	37.7
Numerator	632
Denominator	1,677
Data Source	MCH Data Matrix
Data Source Year	2022
Provisional or Final ?	Provisional

Annual Objectives		
	2024	2025
Annual Objective	45.0	55.0

Field Level Notes for Form 10 NPMs:

None

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**	**2021**	**2022**
Annual Objective			42	43
Annual Indicator	41.2	41.2	46.7	46.7
Numerator	2,724	2,724	5,624	5,624
Denominator	6,612	6,612	12,055	12,055
Data Source	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD	MCH-JS-CHILD
Data Source Year	2019	2019	2021	2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			42	43
Annual Indicator				80.3
Numerator				14,023
Denominator				17,455
Data Source				Dept of Education
Data Source Year				2022
Provisional or Final ?				Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	44.0	45.0	46.0

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**	**2021**	**2022**
Annual Objective	40	45	50	55
Annual Indicator	23.2	23.2	14.5	14.5
Numerator	1,680	1,680	1,660	1,660
Denominator	7,251	7,251	11,431	11,431
Data Source	MCH-JS	MCH-JS	MCH-JS	MCH-JS
Data Source Year	2019	2019	2021	2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	35	40	45	50	55
Annual Indicator	0	23.2			79.9
Numerator	0	1,680			6,826
Denominator	100	7,251			8,547
Data Source	-- State --	State			MCH Program
Data Source Year	-- State	State			2022
Provisional or Final ?	Provisional	Provisional			Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.0	65.0	70.0

Field Level Notes for Form 10 NPMs:

1.	**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**	**2021**	**2022**
Annual Objective			2	3
Annual Indicator	10.4	10.4	3.2	3.2
Numerator	167	167	73	73
Denominator	1,607	1,607	2,245	2,245
Data Source	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN	MCH-JS-CSHCN
Data Source Year	2019	2019	2021	2021

State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			2	3
Annual Indicator				92.4
Numerator				2,352
Denominator				2,545
Data Source				CSHCN program
Data Source Year				2022
Provisional or Final ?				Provisional

Annual Objectives			
2023	**2024**	**2025**	
Annual Objective	4.0	5.0	6.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The definition of medical home in the FSM denotes at least one provider that can provide CSHCN service to the CSHCN client.

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

State Provided Data			
	2020	2021	2022
Annual Objective			7
Annual Indicator		2.3	1.5
Numerator		557	373
Denominator		24,576	25,621
Data Source		FSM Data Matrix	MCH Program and Census
Data Source Year		2021	2022
Provisional or Final ?		Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	12.0	15.0	20.0

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					
	2018	2019	2020	2021	2022
Annual Objective	75	22	27	20	25
Annual Indicator	19.4	14.6	10.8	10.8	9
Numerator	4,384	384	2,526	2,509	1,975
Denominator	22,610	2,629	23,492	23,270	21,872
Data Source	MCH program and Census	MCH program	MCH Program	FSM Data Matrix	MCH Program and Census
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	35.0	40.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			30
Annual Indicator		27.1	15.8
Numerator		458	253
Denominator		1,687	1,600
Data Source		FSM Data Matrix	MCH Program and Vital stats
Data Source Year		2021	2022
Provisional or Final ?		Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	35.0	40.0	45.0

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

State Provided Data			
	2020	2021	2022
Annual Objective			10
Annual Indicator		6.7	24
Numerator		1,336	3,828
Denominator		19,929	15,925
Data Source		FSM Data Matrix	Public Health and Census
Data Source Year		2021	2022
Provisional or Final ?		Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	30.0	40.0	60.0

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of parents/caregivers receiving components of the medical home training

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	10
Annual Indicator			80	30.9
Numerator			44	17
Denominator			55	55
Data Source			FSM Data Matrix	CSHCN program
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	50.0	60.0

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

State Provided Data				
	2019	2020	2021	2022
Annual Objective				15
Annual Indicator			10.2	11.2
Numerator			1,652	2,068
Denominator			16,216	18,428
Data Source			MCH Programs	MCH Program and 2020 Census
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	20.0	30.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Data is estimated during al Public Health outreaches in the communities.

ESM 4.1 - Percent of new mothers who attended breastfeeding group workshops

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	37.7
Numerator	632
Denominator	1,677
Data Source	MCH Program and Vital stats
Data Source Year	2022
Provisional or Final ?	Provisional

Annual Objectives		
	2024	2025
Annual Objective	45.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Percent of schools providing at least 60 minutes daily physical activity opportunities for students before, during and after school day.

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			60	70
Annual Indicator			79.2	57.5
Numerator			10,793	107
Denominator			13,620	186
Data Source			FSM Data Matrix	FSM Data Matrix
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	80.0	85.0	90.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This measure will be tracked in 2023. The data provided here in is for previous ESM.

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		35	38	40	20
Annual Indicator		61.5	78.3	15.4	24
Numerator		99	137	1,195	3,828
Denominator		161	175	7,770	15,925
Data Source		MCH program and Education	MCH program and Education	FSM Data Matrix	FSM Data Matrix
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	30.0	40.0	70.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of CSHCN providers received specialty training from overseas consultants

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective				90
Annual Indicator			97.1	30.9
Numerator			1,518	17
Denominator			1,563	55
Data Source			FSM Data Matrix	FSM Data Matrix
Data Source Year			2021	2022
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

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 components of the medical home training
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 components of the medical home training **Denominator:** Total number of parents/caregivers during the reporting year
Healthy People 2030 Objective:	Improve care coordination through components of the medical home training
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 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 4.1 - Percent of new mothers who attended breastfeeding group workshops
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the percentage of infants exclusively breastfed up to 6 months in the FSM.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of new mothers who breastfed their infants exclusively through 6 months **Denominator:** Total number of all new mothers in a calendar year
Data Sources and Data Issues:	FSM MCH Program service data and Vital Statistics
Evidence-based/informed strategy:	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 abnormal-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.
Significance:	The 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 is important as it also determines a child's future health.

ESM 8.1.1 - Percent of schools providing at least 60 minutes daily physical activity opportunities for students before, during and after school day.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Improve child health through healthy weight with physical activity and nutrition promotion
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 schools with children ages 6 – 11 years who participated 60 minutes of physical activities in school</td></tr><tr><td>**Denominator:**</td><td>Total number of schools with children ages 6 – 11 in the state</td></tr></table>
Data Sources and Data Issues:	Public Health Outreach Data, Dept. of Education records and data
Evidence-based/informed strategy:	Children 6-11 years old who participated in school physical activities for at least 60 minutes per day are found to be healthy.
Significance:	Children attending schools with PE periods and after-school programs have healthy weights and physically healthy.

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 received specialty training from overseas consultants
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the percentage of identified CSHCN provided with specialty training
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 CSHCN providers received specialty training from overseas consultants</td></tr><tr><td>**Denominator:**</td><td>The total number of CHSCN providers during the reporting year.</td></tr></table>
Data Sources and Data Issues:	CSHCN sign in sheets and Registry
Significance:	Training and care coordination leads to a well functioning system of care for CSHCN and their parents and care givers.

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 2022

	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	Quarterly	0		
2) Vital Records Death	Yes	No	Annually	12	No	
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	0	Yes	
7) Hospital Discharge	Yes	Yes	More often than monthly	1	No	
8) PRAMS or PRAMS-like	No	No	Never	NA	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None