Maternal and Child Health Services Title V Block Grant

Federated States of Micronesia

FY 2016 Application/ FY 2014 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS
FSM National Government
Capitol Street, P.O. Box PS 70
Palikir, Pohnpei 96941
Federated States of Micronesia
Tel: (691) 320-2619/2643/2872 •E-mail: health@fsmhealth.fm •Fax: (691) 320-5263

July 10, 2015

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

Dear Sir or Madam:

Transmitted herewith please find a Competing Five (5) Year MCH Grant Application from the Federated States of Micronesia seeking funding assistance for Maternal and Child Health Program Services for the Grant Period 2016–2020.

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

Once again, thank you for this partnership.

Sincerely,

Mr. Arthy G. Nena
Acting Secretary, FSM Department of Health and Social Affairs

Sent electronically:

DIVISION OF HEALTH SERVICES | DIVISION OF SOCIAL AFFAIRS

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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The **Federated States of Micronesia** (FSM), an island-nation in the Western Pacific Ocean which is in free association with the United States, consists of approximately 607 islands, with four island groupings or states (Chuuk, Kosrae, Pohnpei and Yap). The FSM government is submitting this grant application, in response to the announcement from HRSA for availability of funding for MCH Program Services for the period "2016 to 2020 Program Cycle to implement its Maternal and Child Health (MCH) Program in each of its four states' Health Departments based on an integrated health model in a scattered island environment. This application is requesting a sum of $2,873,245 for a period of five years to strengthen MCH Program Services in the FSM.

1. Problem Statement

FSM has a very high percentage of families living below the federal poverty level, resulting in a very large underserved population who are not receiving recommended annual preventive health services. The FSM has a high rate of teen pregnancies (43.6 per 1,000 women 15-17 years), relatively high infant mortality rate (21.5 per 1,000 live births) and a low birth weights percentage of 11% of live singleton births. The FSM National Government provides coordination of services and supplies between the states and the four separate, autonomous state governments are primarily responsible for delivery of services. This poses a coordination challenge that impacts the efficiency of service delivery. The health delivery system is set up in a 'hospital oriented' way, with the majority of resources being allocated to curative rather than preventive services. Currently, most MCH Program services and related preventive health services are centralized at the major clinic in the State's Divisions of Public Health, limiting accessibility to on-going high quality MCH and related preventive health services by the hard to reach communities and vulnerable populations.

2. Implementation Plan and Approach

Every five years, the Federated States of Micronesia (FSM) is required by the Title V legislation to develop a comprehensive statewide needs assessment. 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 critical to program planning and development and enables the State to target services and monitors the effectiveness of interventions that support improvements in the health, safety and well-being of the MCH population. 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 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. The needs assessment served as a vital planning

process for determining where best to focus FSM's MCH efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. FSM also employed a strategic planning process to examine how these new priority areas can be incorporated into the existing MCH scope of work. The FSM's needs assessment process was guided by the MCH Needs Assessment Steering Committee which comprised of the National MCH Coordinator, Family Planning Program Coordinator, National CSHCN Physician, the four State MCH Coordinators and a contracted consultant in partnership and collaboration with our Stakeholders. Stakeholders included representation from national and state MCH programs (including MCH Needs Assessment Steering Committee members), 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. Stakeholders included representatives from public health and other governmental agencies (e.g., the FSM Department of Education and Department of Safety, etc.), staff from community-based organizations and advocacy/interest groups (e.g., Chuuk Women's Counsel, Our Yap, etc.) along with health care providers/organizations (e.g., The Wa'ab and Pohnpei Community Health Centers, etc.) and academic partners (College of Micronesia). Criteria used for selecting stakeholders included their area of expertise and workplace setting (e.g., geographic perspective), 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.

As an outcome of the Needs Assessment, the following nine priority areas were identified as the priority for which MCH resources will target for the next program cycle:

1. Improve women's health through cervical cancer and anemia screening;
2. Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding;
3. Improve child health through providing vaccinations and screening for developmental delays;
4. Reduce childhood injury;
5. Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide);
6. Provide a transitional services for youth identified as having Special Health Care Needs;
7. Improve identification of CSHCN through screening for developmental delays;
8. Improve oral health of children;
9. Reduce tobacco use in pregnant women

FSM chose the following eight national performance measures (NPM) by domain:

Women's/Maternal Health

NPM 1. Increase women receiving a well woman visit including Pap or VIA

Infant/Perinatal Health

NPM 4. Increase women reporting exclusive breastfeeding through 6 months

Children's Health

NPM 6. Increase children receiving developmental screening

NPM 7. Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9

Adolescent Health

NPM 10. Increase adolescents receiving a well visit

Children with Special Health Care Needs

NPM 12. Increase CSHCN receiving transitional services

Cross-Cutting

NPM 13. Increase children receiving a preventative dental visit

NPM 14. Decrease percent of women who use tobacco during pregnancy

FSM MCH Program and partners developed the following state performance measures to address the priorities:

Increase children receiving routine vaccines

Increase women and infants screened for anemia

Increase pregnant women screened for Gestational Diabetes

Reduce infant/fetal death

Increase newborns screened for hearing

The assessment of the data shows that the health status of the MCH Population had not improved substantially. In fact, in some areas it shows that health status outcomes had worsened. The FSM MCH Program has planned for and will continue with 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. Management training programs will be conducted directly for the program managers and service providers as a means to improving efficiency and effectiveness of the program. The services will be conducted at public health clinics, community clinics, local parish halls, schools, community centers and sport facilities in close cooperation with more than ten local community organizations. MCH Program outreach workers with community experience will work with individuals and organizations to promote participation by support groups, such as the mental health and tobacco coalitions, to also generate demand. They will conduct follow-up by contacting the participants to determine whether the information gained through the program is being applied in their daily lives.

3. **Evaluation Method**

Both process and outcome evaluation methodologies will be utilized. Unmet need for the MCH Program and rates of service indicators will be used for evaluating clients' needs for services during the project period. Infant and maternal mortality and morbidity rates will be used as outcome indicators. Other process criteria for evaluation will include: the total number of unduplicated clients attending MCH Program services; numbers served versus the target number; the extent of community interest and support for the program. Monthly and quarterly statistical and narrative reports will be used and on-site monitoring will be conducted. Technical assistance will be provided from the National Government as well as AMCHP and other regional and international organization providing program of assistance to the FSM.

II. Components of the Application/Annual Report

II.A. Overview of the State

Although the total area encompassing the FSM, including its Economic Exclusive Zone (EEZ), 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.

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

The State of Kosrae, the only single-island state, is the furthest southeastern point of the four states. Kosrae is the second largest inhabited island in the FSM with a land area of approximately 42.3 square miles. Because of the steep rugged mountain peaks, all of the local villages and communities are coastal communities connected by paved roads. Travel around Kosrae island is not difficult and it is possible to drive from one end of the island to the other end in approximately two hours. The state is divided into the four municipalities of: Lelu, Malem, Utwe, Tafunsak. The community of Walung (approximate population of 200) is part of Tafunsak municipality, is isolated and only accessible by a ½ hour boat ride at high tide. Of the total Kosrae population of 6,616 residents, 2,173 people reside in Tafunsak, 2,160 persons in Lelu, 1,300 in Malem, and 983 residents on Utwe. Approximately 47% (3,135 persons) is less than 20 years of age and of that group 798 (12%) are less than 5 years of age. The population of women 15-44 years number 1,369 and comprise 20.6% of the total female population.

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 (410 miles from Pohnpei proper), Nukuoro (308 miles), Sapwuahfik (100 miles), Oroluk (190 miles), Pakin (28 miles), and Ant (21 miles). To the east lie the islands of Mwoakilloa (95 miles) and Pingelap (155 miles). These outer islands together comprise a land mass of approximately 133 square miles and 331 square miles of lagoons. Travel on the island of Pohnpei proper is increasingly easier to outlying communities with the completion of pavement of the road around the island. However, because of scattered housing along feeder unpaved dirt roads, there are still many residents who have difficulties in accessing health care, including family planning. The outer islands are the most difficult to reach because of the infrequent and undependable cargo ships. The regular field trip on the ship takes place once a month to each of the outer islands. The population of Pohnpei is 35,981 residents. Based on the annual population growth rate, the population is projected to reach 37,626 by the year 2015.

About half (46.7%) of the population (16,832 persons) are less than 20 years of age with the median age of 21.8 years. There are 8,250 women of child-bearing age between 15-44 years comprising 46.4% of the female population.

The State of Yap lies in the western most part of the FSM. Yap proper is the primary area in Yap state and is a cluster of four islands (Yap, Gagil-Tomil, Maap, 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 family planning services because of unpaved dirt roads. The outer islands are also difficult to reach because of infrequent cargo ships. The regular ship field trip is once a month to each of the outer islands bringing supplies and health personnel to deliver goods and services. The population distribution are: *Yap Proper* with 64.7% (7,371 persons); *Ulithi Lagoon* has four inhabited islands (Asor, Falealop, Fatharai, Mogmog) with a population of 847 residents (7%); *Wolaei* is comprised of two lagoons (the West Lagoon and the East Lagoon) with five of the 22 islands inhabited with a population of 1,039 persons (9%); *Fais*, population 294; *Eauripik*, population 114; *Satawal*, population 501; *Faraulep*, population 193; *Ifalik,* population 578; *Elato*, population 105; *Ngulu*, population 6; and *Lamotrek*, population 329. The median age for Yap is 25.1 years; the highest median age among the four states. Approximately 42.7% are under 20 years of age (4,864 persons). There are 2,545 women between 15-44 years, which is 44% of the total female population.

Based on the 2010 Census, the total population of the FSM is 102,624 residents. Kosrae, with the smallest population, has 6,616 residents (6.4%); then Yap with 11,376 persons (11%); then Pohnpei state with 35,981 (35.2%). Chuuk has the largest population with 48,651 residents (47.4%). There are 22,970 women of child-bearing years of 15-44, which is 22.3% of the total population. The population structure continues to show that 48,528 (47.2%) of the residents are under 20 years and children under five-years comprise 12,042 or 11.7%. Between 2000 and 2010, FSM's population declined by 4,344 persons. The rate of population growth in FSM and the four states has declined dramatically over the past three decades. At the national level, annual growth had dropped from 3.0% in the 1980-89 period to -0.4% over the 2000-2010 period. At the state level, Chuuk and Kosrae have negative growth while in Pohnpei and Yap the rate of growth is still positive but very low at 0.4 and 0.1%, respectively. While declining fertility has contributed to the drop in the population growth rate, out-migration to the United States and other parts of Micronesia is the primary cause of the negative growth. The determinants of the differential rates of out-migration at the state level are complex; economic performance is a contributing factor, which is changing the distribution of population across the four states with Chuuk and Kosrae losing population share. Pohnpei is gaining share and Yap is remaining constant. 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 of 102.7 indicates 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". Long-range population projections suggest that little population growth can be expected in FSM for the foreseeable future. While projections to 2030 suggest virtually no population growth from 2010 onwards and less that 10 percent total growth up to 2050, significant demographic changes are predicted. If the population growth remains unchanged, the projected number of FSM population by the year 2020 would approximately reach 106,567. Each state is

comprised of a state center, intermediate areas and, with the exception of Kosrae, outer islands. The state center is the largest of the islands and is the center of commerce and government. Approximately 22.3% of the FSM population in 2013 was projected to live in the state administrative centers. The state centers and intermediate areas contained about 70.0% of the total population, with the remainder living on the outer islands. The high densities of the populations in the state centers are due to a slight trend for rural and outer island migration to the state centers and a high fertility rate within the FSM. People from the out-lying municipalities and the outer islands migrate to the state centers, seeking wage-earning employment, access to better (and secondary) education, medical care, and the different amenities of urban life. The concentration of population into the state centers has continued to increase in the last many years. The distance between these states and the national capital approximates 2,391 miles. “Intermediate areas” refers to those areas which require more than two hours travel time from the state center but less than one day. The term “outer islands” refers to those areas, which require more than one day’s travel to and from the state center. The average travel distance from state centers to the outer islands or island groups varies from 0 in Kosrae to 620 in Yap and from state centers to the FSM National Capital from 190 in Pohnpei to 1,611 in Yap. While the average nuclear family consists of approximately five-six persons, people typically live in larger extended families. Consequently, the family income, land and other resources are highly diluted. However, the concept of extended families is slowly changing. People realize that resources are not only becoming insufficient through this system, but it does not provide incentives for family members to support themselves. The extended family may not be able to provide the necessary financial, material and emotional support to the large numbers of children and the breakdown of traditional norms may further weaken the family and other traditional institutions, with consequences on social stability. The waning of the traditional family support, coupled with the high dependency ratio, have the potential to also affect demand for imported food, jobs, housing, potable water, education, medical care and other social services.

The adolescent and youth have been identified as a group for special interest for the population because of their disproportionately higher likelihood of unintended pregnancies, lack of knowledge of family planning and difficulty in accessing services. FSM has a young population with more than 37% of persons aged 19 years or younger. While the total youth population, as defined by FSM as 15-34 years, appears to be stagnating the absolute numbers of youth are high and exceed 35,000 persons. About 35% of the FSM population is persons aged 15-34 years, with 52% males and 48% females. Almost half of the FSM youth reside in Chuuk, 35% reside in Pohnpei State, 10% reside in Yap and the remaining 6% reside in Kosrae. More than a third of this youth population is between the ages of 15-19 years. The high percent of the population in the young age group has implications for planning social services, including family planning. Of those youth 15-19 years about 5% were married. About 7% of the girls of this age group have borne a child. While the rate has decreased over the past decade, the high rate of unintended pregnancies among teenage girls remains a cause of concern and special programs aimed at adolescents have been initiated. Teenage mothers are less likely to complete schooling or to progress to higher education, risking socioeconomic, educational and health disadvantages. Similarly, children of teen parents are more likely to grow up poor and have significant problems. With the high percentage of the population below 15 years of age (36%) yet to reach the reproductive age, this issue related to adolescents is unlikely to improve in the near future. The economic situation of youth is somewhat precarious. With public sector jobs declining and private sector jobs virtually static, the employment prospects even for high school or university graduates do not look promising. The rate of unemployment among 15-19 year-old is the highest of any age group and has increased recently. Approximately 39% of the youth population 15-34 years is employed while 55% are not in the labor force. The lack of job opportunities for the young generation also has the potential of creating social and political problems. Youth also face a range of health and social problems, including the risk of HIV and other STIs, alcohol and drug abuse, unwanted pregnancy, early marriage, and suicide. Male youth in FSM have an extremely high suicide rate, which appears to be related to feelings of alienation from traditional authority, exacerbated by high alcohol use. About 5% of the youth population reported to be with severe physical or mental difficulty. The National Youth Policy (2004-2010) which aimed to address these problems, with a particular focus on high-risk or particularly disadvantaged youth, is currently being updated.

The FSM, a society in rapid transition, is composed of four different societies with twelve different major languages: Kosraean in Kosrae; Pohnpeian, Kapingamarangian, Nukuoran, Mortlockese, Mokilese Ngatikese and Pingelapese in Pohnpei; Chuukese and Mortlockese in Chuuk; and Yapese and Ulithian in Yap. English, however, is the official language of the governments and is taught in the schools. Additionally, many older people are familiar with Japanese language. In Kosrae, the Congregationalists, a religious group who came from the Boston area of the United States during the late 1800's, largely influence its culture. Countries, which added their own influence during the 1900's included Spain, Germany, Japan and the United States. Although there are a number of minor differences in cultural patterns between the state center and the outlying islands, the State of Chuuk is composed of people who basically share one culture and one language. Pohnpei has six distinct cultural groups. They are Pohnpeians; Mortlockese, a group of people, from the outer islands of Chuuk State, who sought refuge in Pohnpei after the typhoon of 1905; Polynesians from Kapingamarangi and Nukuoro; and Pingelapese, Mokilese and Ngatikese on the atolls of Pingelap, Mwokilloa and Sapwuafik, respectively. In Yap, there are two major cultural groups and two major languages. The inhabitants of Yap Proper speak Yapese and belong to one culture while the inhabitants of the outer islands speak a language of Chuukese origin and share the Chuukese outer islands culture. Cultural attitudes and practices continue to influence the impact of the health care delivery system, the uptake of family planning services and the health status of FSM residents. Islanders have not completely understood the concept of medical confidentiality and many people continue to be reluctant to be seen or examined by the physician, nurse or health aide. In small communities, most everybody is related to one another and it is considered culturally unacceptable for relatives to see each other's private parts. Because of their reluctance as well as lack of understanding of preventive measures, some people only seek medical care when they have to and when it is too late. Many women are reluctant to undergo gynecological examinations by a male health care provider. In outer islands, most of the health assistants and medexes are males to whom the majority of the women in the community are related. Post-natal clinics in public health programs are often impeded because of a belief that women should not be seen or examined after delivery until the bleeding has completely ceased. Many Micronesians continue to believe that certain illnesses or diseases are brought upon a person by gods and/or ancestors for various reasons. Because of such beliefs, certain illnesses are believed to be remedied only by reconciliation with the gods, families or individuals and cannot be remedied by Western medicine. These factors and others affect the health seeking behavior of Micronesians, including for family planning services, and concomitant efforts to alter behavior generally meet with resistance. Various orthographies have been developed for the major local languages, but it is estimated that only one-half of the adult population (over the age of 40) can read and write in their own languages. Thus, health education in the modern sense, including family planning counseling, has not been part of the school curriculum, nor part of the local cultures. Strong conservative attitudes held by adults, language and logistic problems impact health education, including sexuality and family planning education.

The FSM is vulnerable to severe weather events, such as cyclones, tsunamis, and tidal surges. The low-lying atolls are the most vulnerable, but high islands are subject to coastal erosion, especially with increasing urbanization. Some states, like Chuuk, have excessive waste and leakage in its water systems, which prevents 24-hour service, leading to contamination of water lines as well as poor water supplies affecting the delivery of public health services, including family planning services.

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 2005, the FSM per capita income was estimated at $1,983. Yap and Pohnpei had a much higher per-capita income at $2,900 and $2,100 respectively. Chuuk and Kosrae had lowest per-capita income at about $1,700. About 61%, close to two thirds, of households in the FSM had per-capita income of less than $2,000. The proportion of households with per-capita income of less than $2,000 was highest in Chuuk at about 74% and lowest in Yap (44%). The average household size was 6

persons. Approximately 54% of the households in FSM have incomes less than $10,000. Two thirds or 66% of all households in Chuuk had total income of less than $10,000. The corresponding figure was 35% in Yap and 47% in Pohnpei and Kosrae.

The HIES indicated that about 31% of households in the FSM had incomes below the estimated national basic needs poverty line of US$768 per person per year. The proportion of the FSM population falling below the "basic needs" poverty line has increased. Kosrae had the highest poverty rate (34.5%) and Yap the lowest (19.4%), but food poverty was highest in Chuuk (12.2%) and lowest in Yap (4.0%). In FSM, the individuals living below the national poverty line tend to have low educational achievement and live in households without a wage or salary worker and/or are headed by a female. The impoverished include the unemployed, the uneducated, the landless, teenage couples with children, widows and widowers and households with many children who lack support from an extended family. The level of poverty has an impact on the health status of population in the FSM, particularly women of child bearing age. The need for family planning among the poor remains high.

The FSM basic needs poverty line is much lower than the US poverty thresholds. At present, social, education and health programs are funded primarily by U.S. Compact funds, which was renegotiated in 2001and went into effect in 2004 and is currently decreasing. It is estimated that approximately 95% of the service population of the FSM falls below the U. S. Income Poverty Guidelines (Federal Register in 2005). World Bank estimates for 2010 indicate that FSM has a GDP per capita of $2,678 while the US equivalent is $47,199. It is also significant that in the FSM, other than the limited distribution of Social Security payments, there are no cash-supplemented welfare programs. Therefore, there should be no charges for services provided to family planning recipients in the FSM. FSM is not eligible for Title XIX (MEDICARE) Program.

Transportation within and between states significantly impacts the quality and coordination of health care, including family planning services. United has scheduled regular flights with three flights per week in each direction. Yap is additionally serviced by Pacific Missionary Aviation (PMA), which makes regularly scheduled trips from Yap to Ulithi and Woleai atolls. With the exception of Ulithi and Woleai Atolls, no other outer islands in Yap receive air transportation. Caroline Pacific Air (CPA) now services Pingelap, Mokil and Sapwuafik, three of the outer islands of Pohnpei, twice a week to each island and Ta Atoll, in the Mortlocks, Chuuk, weekly. Field trip ships, on which health service field teams make intermittent trips to the outer islands, are operated by the State Transportation Departments in each state. In cases of medical emergencies, these ships and/or the PMA and CPA airlines evacuate patients. Transportation within individual lagoons, provided by small private motor boats or canoes, is very expensive.

While FSM Telecommunications Corporation system, which serves within and outside the FSM, has improved considerably, the cost of making overseas telephone calls is prohibitive. Fax, telex and email are readily available. High-Speed, Wireless Internet Connections are used by state and national governments, with varying degrees of connectivity. The evolution of internet communication has the potential to revolutionize communications within and between states affecting health care delivery, including family planning services.

The health status in the FSM, though varying from one state to another, has improved appreciably in the past 10 years. There is potential, however, for further improvement if complex health, cultural and economic issues can be resolved.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Goals and Vision:
Every five years, the Federated States of Micronesia (FSM) is required by the Title V legislation to develop a comprehensive statewide needs assessment (NA). This NA requires ongoing sources of information about maternal and child health (MCH) status, risk factors, access, capacity and outcomes. The NA 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.

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. The FSM developed this view collaboratively by discussing the overall framework with the MCH Needs Assessment Steering Committee (described below) 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 domains of women/maternal, perinatal/infant, children, adolescents, children with special health care needs, and cross-cutting. The overall goal of the process focused on identifying a set of definite priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based interventions grounded in sound public health theory or research and consistent with the mission and scope of FSM's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process focused on meaningfully involving multiple national, state and community stakeholders/partners to enhance collaboration, while looking for opportunities to coordinate and integrate MCH efforts externally and internally across the MCH continuum.

The NA served as a vital planning process for determining where best to focus FSM's MCH efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. FSM also employed a strategic planning process to examine how these new priority areas can be incorporated into the existing MCH scope of work.

Leadership and Stakeholders:
FSM's NA process was guided by the MCH NA Steering Committee which included the following staff members:

- Dionis Saimon, MCH Program Coordinator;
- Stanley Mickey, Family Planning Program Coordinator;
- Dr. Anamaria Yomai, CSHCN Physician;
- Pipiana Wichep, Chuuk MCH Services Coordinator;
- Patricia Tilfas, Kosrae MCH Services Coordinator;
- Marcy Lorrin, Pohnpei MCH Services Coordinator; and
- Denitha Palemar, Yap MCH Services Coordinator.
- The group was assisted by Arielle Buyum, who served as facilitator and process consultant.

With leadership from the MCH Coordinator, this group established the overall strategic direction and methodology for the NA while providing the ongoing project management and oversight for the process. In April 2015, National

members of the Steering Committee and the consultant traveled to each State to conduct individual State NAs. The State meetings were well attended with 42 staff and diverse community members including men participating in Kosrae, 30 in Pohnpei, 26 in Yap, and 27 in Chuuk. In June 2015, the Steering Committee and select State representatives met in Pohnpei to finalize the priority needs as described below. This two part process allowed for individual State input from staff, health and community partners, families, consumers and other key stakeholders into the overall National level NA.

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

Stakeholders included representation from national and state MCH programs (including MCH NA Steering Committee members), 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. Stakeholders included representatives from public health and other governmental agencies (e.g., the FSM Dept of Education and Dept of Safety, etc.), staff from community-based organizations and advocacy/interest groups (e.g., Chuuk Women's Counsel, Our Yap, etc.) along with health care providers/organizations (e.g., The Wa'ab and Pohnpei Community Health Centers, etc.) and academic partners (College of Micronesia).

Criteria used for selecting stakeholders included their area of expertise and workplace setting (e.g., geographic perspective), 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.

Methodology:
FSM assessed the needs of the MCH population using Title V indicators, performance measures and other quantitative and qualitative data. The Steering Committee reviewed major morbidity, mortality, health problems, gaps and disparities for the MCH population in order to identify specific needs by MCH population domain based on analysis of data trends. The cross-cutting needs were also examined. The Steering Committee spent several sessions determining data needs and gaps, and reviewing data findings.

Specifically, the Steering Committee:
• Reviewed the 2010 NA and interim NA findings and noted trends since the last assessment;
• Reviewed recent state, regional and national reports to determine possible issues/problems to be explored in the FSM;
• Reviewed recommendations made by various task forces;
• Identified major data/indicators including trends of health status, access, health needs and health disparities to be included in the assessment for each domain; and
• Determined stakeholder and public input processes.

Quantitative methods used for assessing needs for each of the population domains included a review of various the data sources including Vital Statistics Data, FSM Census Data, Surveillance Systems and Registries, Mortality Reviews, and other FSM Agency Data and Reports. The Steering Committee developed a set of MCH indicators to guide this phase of the work. Findings were also used to populate the MCH Priority Health Issues Survey.

Qualitative methods included the use of the aforementioned survey to MCH clients, stakeholders, parents and

community members. MCH received 130 completed surveys covering the six domains. Survey participants chose their top five issues for each domain, while also identifying any important issues not reflected in the original list. Of the new issues identified, most had been considered by the Steering Committee in earlier phases of the NA process. In addition, qualitative data was a review of state plans and reports prepared since the last NA.

At the end of the above process, results were summarized from all activities and presented to the Steering Committee. As expected, the focus areas identified across approaches overlapped due to the impact that many of the issues exert throughout the life course. This phase concluded with the identification of 21 potential MCH priorities spanning the six domains. The Steering Committee met concerning the potential priorities identified with the goal of further refining and prioritizing the issues.

Prioritization criteria included considering potential issues 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.
• Structural Resources: Financial, human, and material resources; policies and protocols; and other resources needed for the performance of core functions.
• 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.
• Competencies/Skills: Knowledge, skills, and abilities of MCH staff.
• Organizational Relationships: Partnerships, communication channels, and other types of interactions and collaborations with public and private entities.
This phase concluded with the reduction to 15 potential MCH priorities.

Next was the final prioritization process and state capacity assessment to determine the MCH priorities for FY2016-2020 and in keeping with the guiding principles of the process, the Steering Committee focused on the goal of identifying select areas for MCH investment, so that a comprehensive set of interventions could be employed at more depth to affect five-year outcomes. In addition, the chosen priorities needed to be tied to the MCH scope of influence in order to assure ultimate impact. In order to do so, the Steering Committee was charged with connecting each potential priority to a national or population-based outcome measure. To this end, the Steering Committee prepared a justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period. Following these discussions, each issue was ranked, using a grid specifying impact and feasibility along an x and y axis. This, along with the assessment of state capacity, served as key resources for discussion in determining the final set of nine priorities.

Realizing the dynamic nature of MCH as well as the depth and breadth of issues specific to these populations, FSM will continue to systematically assess needs during the upcoming five-year time frame. Specific work plans will be developed for each priority with goals, objectives, activities and evaluation measures that will drive state and local MCH-level activities from FY 2016-2020. As noted above, MCH resources will be allocated and/or shifted to implement the new priorities which will include ongoing evaluation.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health:
All clinical sites within FSM Public Health perform women's preventive health exams. However, in 2013 only 7.6% of MCH women had a Pap smear at these clinical sites, see Table 1 below. It is important to note that in Pohnpei and Yap visual inspection with acetic acid (VIA) is used as an alternative to Pap testing which is not reflected in the data below. Even so, the FSM has a very large underserved population who are not receiving recommended annual preventive health services. Many women are not receiving adequate preventive health care. As in many underserved communities with a high percentage of families living below the federal poverty level, these women face many barriers to care, including: unaware of health needs; shame or fear in seeking reproductive health services; access to care issues; uninsured status; transportation issues; and childcare issues.

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

Percent	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	37.0	24.0	22.3	7.6	16.2
Chuuk:	47.0	30.0	30.0	30.0	30.0
Kosrae:	34.0	47.0	30.0	47.8	43.9
Pohnpei:	0.0	10.0	10.0	10.0	10.0
Yap:	94.0	24.0	9.0	1.0	26.0

Source: MCH Program Data

The FSM maternal health clinics serve as many women's first entry into medical care or their medical home. MCH recommends and provides preventive health services in accordance with recognized standards of care. The program aims to improve the number of clients that follow the recommended standard of care in preventive health services through increased education and outreach efforts and collaboration with community-based programs. Because the preventive health clinics of the FSM all exist within the public health facilities, clients can avail themselves of multiple public health screening and preventive services in one visit. In this way, The MCH Program serves as the gateway to care through partnerships with other public health programs. The MCH Program works closely with the Family Planning Program, Tobacco Control Program, STD/HIV Prevention Program, and other health and social programs. Once again, clients need not make multiple appointments or visit multiple clinics to participate in these program services, thereby allowing for comprehensive and cohesive preventive health care. An assessment of prenatal care conducted at the only hospital in the FSM showed that almost 70% of deliveries receive inadequate prenatal care, see Table 2 below. Use of the Kotelchuck data results in a large percentage of prenatal care being labeled inadequate, solely because it starts after the fourth month. However, analysis of data using trimester prenatal care began or using percentage of expected visits attended, confirms the Kotelchuck findings. In addition, some FSM states report up to 10% of deliveries received no prenatal care at all. MCH Program continues to strive to improve prenatal care adequacy. The process of prenatal care at the clinic may be a deterrent to some women. Prenatal care is only offered on certain clinic days and not by appointment. This means there is limited availability of services that women may have difficulty fitting into their schedules. It also means long wait times in crowded waiting rooms. Besides wait time, the process of being seen is still long as there are many steps to the visit. In some locations, the woman must check in at one location, see the provider at another, then go to a third location for lab draws and a fourth location for the dental check. Streamlining the process may increase prenatal care attendance.

Data shows that less than 50% of women come in for care during the first trimester. A survey of at Antenatal Care Clinic in Chuuk showed that long wait time and transportation were the two main reasons women did not access prenatal care.

Table 2 Percent of women with a live birth whose observed to expected prenatal visits are ≥ 80% on the Kotelchuck Index

Percent	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	52.0	46.0	34.6	33.2	34.5
Chuuk:	59.0	49.0	17.3	30.0	30.2
Kosrae:	73.0	70.0	70.9	64.6	55.0
Pohnpei:	39.0	25.0	68.8	18.4	39.9
Yap:	39.0	50.0	67.4	69.4	13.4

Source: Birth Certificate

Even amongst those seeking prenatal care, that care is not always adequate. Some clinic locations lack dopplers and ultrasounds (Pohnpei) others lack basic supplies such as feta scopes, prenatal vitamins, glucometers and urine dipsticks (Chuuk) limiting the diagnostic capabilities of the prenatal care. There is limited pregnancy expectation education so the community is unaware of what to anticipate during pregnancy and prenatal care. During prenatal care not all FSM States currently screen for Gestational Diabetes. Pohnpei does no screening at all, although the lab possess the capabilities. Kosrae and Chuuk do screening based on risk assessment of known history of diabetes or gestational diabetes. Only Yap does routine glucose tolerance testing to screen for 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. As a measure to improve the adequacy of prenatal care and improve fetal outcomes, the FSM MCH Program intends to implement a routine glucose tolerance testing.

In 2010, the FSM MCH Program noticed an increase in women being diagnosed with anemia during pregnancy. In an effort to increase a woman's health status prior to pregnancy the program instituted screening of all women for anemia not just pregnant women. In 2014, 18.3% of women of childbearing age screened had anemia. Anemia screening and treatment is still a necessary measure of all women in the FSM.

Perinatal/Infant Health:
The perinatal mortality rate in the FSM in 2014 was 36 per 1,000 live births, see Table 3 below. According to the National Vital Statistics Reports, the most recent national perinatal mortality rate available was 6.26 per 1,000 live births in 2011. When this data is coupled with the 2014 low birth weight percentage of 11% of live singleton births a scenario begins to form in which unplanned pregnancy, late access and inadequate prenatal care, and poverty play a significant role in poor birth outcomes, causing additional stressors on the family, community, the health care system and the government. As discussed above, lack of screening for gestational diabetes during prenatal care effects newborn outcomes. The MCH Program is committed to improving prenatal care access and adequacy as stated above through the MCH clinics and dispensaries in remote villages.

Table 3 Perinatal mortality rate per 1,000 live births plus fetal deaths

Rate	2010	2011	2012	2013	2014
FSM:	33.0	31.0	27.7	39.0	36.2
Chuuk:	39.0	42.0	23.7	59.3	44.9
Kosrae:	17.0	11.0	34.0	26.5	17.4
Pohnpei:	31.0	28.0	30.0	26.0	31.0
Yap:	28.0	4.0	9.0	21.0	36.0

Source: Vital Statistics

Although in 2014, 62.7% of mothers in FSM report breastfeeding their child at six months of age the adequacy of breastfeeding has not been assessed. This measure does not assess exclusive breastfeeding. The qualitative reports from pediatric providers is that although women are still offering the breast at six months, most are supplementing. Unfortunately, the supplements are not a healthy alternative but often coconut milk. Education needs to be provided to mothers on breastfeeding and infant nutrition. Currently childcare education is lacking in the FSM. New mothers rely on families to inform them about child care and rearing and this is not always the healthiest or safest information. Anemia is prevalent in the infant population of FSM as well as the childbearing woman population as discussed above. In 2014, 35.2% of infants up to 1 year old screened were anemic. However, that same year only 16.6% of the infant population was screened. The MCH Program continues to improve the number of infants screened for anemia due to the high prevalence among the population.

Child Health:
Immunizations are a pillar of child health care. However, the overall coverage rates of immunization in FSM is quite low at 59.2% in 2013, see Table 4 below. Once of the main barriers to immunizations in the FSM is the need for refrigeration of the vaccines, thereby making it difficult to provide to children of the outer and remote islands. This is apparent in the Kosrae specific data. Kosrae is a single island State. In this State without outer and remote islands the 2013 coverage was 90%. In Pohnpei, outreach and services to the outer islands is only done once or twice a year and in Chuuk the schedule is often dependent on having fuel for the boat. FSM MCH Program plans to improve immunizations through education and outreach.

Table 4 Percent of children through age 2 who have completed routine immunizations

Percent	2009	2010	2011	2012	2013
FSM:	67.8	53.1	48.0	50.5	59.2
Chuuk:	65.6	39.0	25.0	37.0	47.0
Kosrae:	97.0	99.0	84.0	16.8	90.0
Pohnpei:	58.0	79.0	52.0	67.3	71.2
Yap:	84.0	45.0	83.0	84.0	87.0

Source: FSM Immunization Program

As evidenced below in Table 5, FSM children experience many non-fatal injuries. It is reported that most of these injuries are falls related to play. Children play in the natural island habitat of the jungle by climbing trees and rocky cliffs and running through sharp coral-rock areas. There are no neighborhood playgrounds offering safe play areas. The MCH Program plans to promote safe play by educating parents to designate areas of play around their homes and villages that offer safer play options in an attempt to reduce injury.

Table 5 Rate per 100,000 of all non-fatal injuries among children aged 14 years and younger

Rate	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	196.0	488.0	147.9	568.0	367.8

Source: Hospital Discharge Records

Currently developmental screenings are only completed on the MCH population but not the population at large. 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. The MCH program intends to extend the screening to age six (6) years through developing age-appropriate tools and increasing efforts to screen all children.

Adolescent Health:
The FSM teen birth rate for 2014 was 43.6 births per 1,000 females, which is greater the national average of 14.1 in 2012[1], see Table 6 below. This population has not followed the US trend towards delaying childbearing. In Pohnpei, there is no marriage age law. In Yap, the legal age of consent is 13 years old. This past year, Chuuk increased the legal age of consent from 13 to 18 years old.

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

	2010	**2011**	**2012**	**2013**	**2014**
Annual Rate:	19.0	12.0	16.2	22.4	43.6

Source: FSM Birth Certificate and Census Data

Teen births increase health risks to both mother and child including low birth weight, preterm birth, and death in infancy. In addition to health risks teen births set up a cycle of disadvantages. Teen mothers are less likely to finish high school and their children are more likely to have low school achievement, drop out of high school, and give birth themselves as teens. For these reason FSM MCH Program works closely with the FSM Dept of Education to prevent teen pregnancy. Clinic locations are at High Schools and the college. Condoms are available at many community locations. The rate of sexually transmitted diseases (STDs) in the FSM is improving. However with limited testing due to financial and laboratory constraints, the rates of Chlamydia may be under reported, see Table 7 below.

Table 7 Rate per 1,000 women aged 15 through 19 years with a reported case of

chlamydia

	2010	2011	2012	2013	2014
Annual Rate:	29.0	13.0	6.2	7.3	13.8

Source: STD Program

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

The MCH Program currently works and will continue to work with youth groups in each State to reach the adolescent population. Such groups are Youth for Change, Chuuk Youth Council, and the Public Health PREP- Personal Responsibility Educational Program.

Risky adolescent behavior such as drug and alcohol use lead to injury such as motor vehicle crashes as presented below in Table 8. Although not much data exists on current drug and alcohol use, it is believed throughout the community that the use does exist and influences poor outcomes. There is lack of law enforcement surrounding alcohol sales and many businesses in the FSM sell alcohol cheap and to youth. Additionally, in the FSM there is a cultural norm to drink sakau, a sedative agent derived from the roots of a shrub, pounded and mixed with water. This is done both ceremoniously in traditional customs and socially. There is no age limit on drinking sakau and is drank increasingly by the youth.

Table 8 Rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

Rate	2010	2011	2012	2013	2014
FSM:	92.0	42.0	28.4	28.3	24.0

Source: Hospital Discharge Records

Teen suicide is an issue in FSM with a rate as high as 61.4/100,000 adolescents being reported in 2014, see Table 9 below. More awareness and education around suicide, its causes and prevention is necessary in the FSM.

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

Rate	2010	2011	2012	2013	2014
FSM:	59.0	9.0	34.7	8.7	61.4

Source: Vital Statistics

Currently the FSM MCH program provides school physicals until age 12. The Program plans to expand these school physicals into the high school grades. During these well adolescent visits, youth will receive information and education on risky behavior and its possible negative outcomes.

Children with Special Health Care Needs:
Currently the FSM does not have a database system to report, track or register a child as one with special health care needs. Therefore, the program does not have an accurate count to determine how many CSHCN are being seen and/or receive appropriate and timely health care case management services. The Program tracks percent of children identified with developmental delays that are part of the CSHCN Program as detailed in Table 10 below. However the numerator is total number of children identified with developmental problems and admitted to the CSHCN Program and the denominator is the total number of children within the CSHCN Program. Therefore the measure of tracking the population is really only a measure of the percent of newly diagnosed CSHCN Program participants for that year. The Program has no specific data on the number or percent of children screened for developmental delays; the number or percent of children found to have developmental delays; nor the number or percent of children with developmental delays receiving services.

Table 10 Percent of children with identified developmental problems that have been admitted to the CSHCN program (as tracked by FSM MCH CSHCN Program)

Percent	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	17.0	3.0	6.4	9.4	5.5

Source: CSHCN Program

The lack of a tracking system is a major shortcoming of the program. Without such a system it is difficult to measure or quantify most aspects of the reach and success of the program. Most children in the program are identified through Child Find a program of Special Education, when diagnosed as deaf or hard of hearing, or seen and referred by Shriners during Shriners annual visit. Diagnosis often depends on specialist visits from off island so MCH provides gap care until the next specialist is on island. Interventions for those with delays do not begin until age 3 with Special Education, therefore the MCH program provides gap care for these children as well. Transitional services for CSHCN are tracked through the CSHCN Survey, see Table 11 below.

Table 11 Percent of youth with special health care needs who receive the services necessary to make transition to all aspects of adult life, including health care, work and independence.

Percent	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	26.0	25.0	10.4	17.1	18.7

Source: Special Education

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

Cross-cutting:
The Public Health Dental Clinics serve the entire FSM community. Training was conducted to public health nursing and support staff for oral health assessment, fluoride varnish application, education/counseling and referral to promote the integration of oral health into clinical services. A dental check is completed free of charge during prenatal care. Dental services are not available at the dispensaries though. There are two private dental clinics in Pohnpei and Chuuk. However, access is somewhat prohibited given that in Chuuk the private clinic is only open for a week every month. The Public Health Dental Clinics, through a Memorandum of Agreement (MOA) with the Early Childhood Education Program and the Department of Education, has the only established school prevention programs in the FSM. Although the purpose of the Fluoride Varnish and Sealant programs is to prevent dental caries among children in the FSM, both medical and dental care providers have noted tremendous deficiencies in the oral health status of children here in the FSM. The prevalence of dental caries remains one of the most unmet health needs especially among young children in the FSM. For most of the children in Head Start, their first dental visit is through the Fluoride Varnish Program. The reach of Fluoride Varnish Program needs to grow, see Table 12 below.

Table 12 Percent of children 1-5 years old treated with fluoride varnish

Percent	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	26.0	21.0	30.1	24.7	28.3

Source: Well Baby Clinic and Early Childhood Education Division of Special Education

Impeding priorities in families' life creates challenges and barriers in seeking preventative health screenings including for oral health. Poor oral health literacy contributes to not seeking preventive oral health services as individuals may not understand the connection of good oral health in relation to their general health. The Public Health dental clinic has to be in the forefront of providing guidance to redefine the roles of health professionals in the delivery of oral health services. The limited oral health workforce also contributes to not accessing preventive care. The heightened oral health issues found in the FSM is due, in large part, to a high incidence of chewing betel nut, especially in Yap State. Betel (areca) nut chewing is often used in combination with tobacco and slaked lime (predominantly calcium hydroxide). Use of betel nut in adults is very high in the FSM, as well as most of Micronesia, and starts at a young age. The age initiation of chewing betel nut is not uncommon to be as young as 12 years. Betel nut is sold in gas stations, grocery stores, and roadside stands and can be obtained from homegrown trees. It is easily available throughout the FSM and there is no minimum age for purchase. It is estimated that up to 85% of the population of Yap State chew betel nut with tobacco. Because addictive, betel nut users don't stop chewing during pregnancy. Therefore a related finding is the high use of tobacco in pregnancy. As part of the last grant cycle data collection, FSM tracked women who reported smoking in their last three months of pregnancy, see Table 13 below. The findings of 0.8% in 2014 are quite low, but this does not assess tobacco use outside of smoking. MCH Program intended to track and reduce not just smoking in pregnancy, but all tobacco use in pregnancy.

Table 13 Percent of women who smoke in the last three months of pregnancy

Percent	**2010**	**2011**	**2012**	**2013**	**2014**
FSM:	2.1	2.0	1.5	1.8	0.8

Source: Antenatal Care Registry

A finding of a need unrelated to a specific domain but cross-cutting through all is the need for improved data collection. The reliability and validity of the data collected by the States and reported to the National MCH Program is questionable. This can be seen in much of the data presented above. The data reported from year to year is quite variable without any justification for the severe fluctuations. It must be a MCH Program priority to improve the data collection and reporting efforts to better understand the current situation as well as monitor change over time and evaluate activities meant to improve MCH population health.

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

II.B.2.b Title V Program Capacity

II.B.2.b.i. 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 MCH Title V and allocated to the FSM Government are further allotted to each State MCH Program by way of Allotment Advices issued by the National Budget Office, now under the administration of the new Office of Statistics, Budget, Overseas Development Assistance, and Compact Management.

At the National level, the Secretary of the Department of Health and Social Affairs (H&SA) manages health affairs for the nation. There are several divisions under H&SA, including the Division of Health Services which houses the Family Health Services Section. The MCH Program is one of the six programs under the Family Health Services Section along with Title X Family Planning, UNFPA Family Health Project, HRSA and CDC funded Early Hearing Detection and Intervention (EHDI) Programs, and State System Development Initiative (SSDI). The Program Manager of the Family Health Services Section also acts as the National MCH Program Coordinator. Please see Attachment #2 Organizational Chart.

The National MCH Coordinator works in collaboration with other coordinators at the national level, such as the Immunization Coordinator, Substance Abuse and Mental Health Coordinator, the HIV/AIDS Coordinator and the Diabetes Control Program Coordinator. 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.

Health services 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.

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. For the planning, implementation and provision of direct services to the maternal, infant, child, and adolescent populations, each state has an MCH Coordinator and a CSHCN Coordinator.

II.B.2.b.ii. Agency Capacity

Within each of the four states, the MCH Programs provides primary care and preventive services to pregnant women, mothers and infants; preventive and primary care for children; and services for children with special heath care needs. The Department of Health Services provides all of the preventive and primary health care services at no cost to the clients.

The staff of the MCH Programs work closely with the staff from other programs to provide the full array of services. Some of the other programs that collaborate with the MCH Program include the family planning program, the immunization program, the school health program, the prenatal care program, and the STD program. Services include medical, dental, mental health, substance abuse counseling, women's health, nutrition counseling, and family planning. Our collaboration with other Public Health programs and community partners makes it possible to bring health services out into the community. Our work is supplemented by enabling services including outreach, case management, educational materials, and transportation to MCH target populations. Below is a description of capacity by domain.

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

Prenatal care is provided at each of the State's Department of Health Services clinic by general physicians or OB/GYNs. For States with neighboring, outer or remote islands, services are provided by Health Assistants at the dispensaries, although women are encouraged to come to the clinic for the first prenatal visit. The first prenatal visit involves an intake/interview by the nurse, physical exam (Pap test), blood work, counseling, and presumptive Chlamydia treatment. The revisit exams include monitoring baby's growth and development, monitoring the mother's health, dental care, nutritional counseling and education. Group Beta Strep testing is done in late pregnancy as recommended. There are OB/GYNs at each State Hospital for referrals of high risk cases such as diabetes and hypertension. Increasing the percentage of women receiving adequate prenatal care visits, especially during first trimester, continues to be a focus for the MCH Program.

Postpartum clinic provides assessment of maternal and fetal health after delivery as well as family planning counseling and contraceptives. Mothers are provided with hematocrit screening, blood pressure and weight check, and physical examination. Mothers are counseled on family planning methods and those who decide on using a family planning method are given their choice of contraceptives also at no cost.

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

Breast cancer and cervical cancer screening exams such as pap smears and clinical breast exams are provided at no cost to women that meet the program's criteria. In addition, program staff conducts outreach presentations on

early detection and prevention including risk factors. Women must travel off island to receive mammograms as no facility in FSM offers them.

Women's Health and Gynecological services are provided at the State clinics. Health screenings such as blood sugar, blood pressure, weight, etc. are provided. This is also conducted during community events. Teams of physicians and nurses travel to the remote islands to provide screening services.

Perinatal/Infant Health and Child Health:
Services are provided at the State Public Health Clinics. Unfortunately due to limited clinic space, infant and child health care is only available at each State clinic on select days. Perinatal health is also described above in Women/Maternal Health prenatal care.

Newborn assessments completed include physical examinations, monitoring of weight gain, and cord care. Breastfeeding is also discussed and education for proper technique or identified issues is completed.

The Immunization Program ensures availability and accessibility of vaccination services at clinics. Supplemental activities are done to provide immunization out in the villages. The staff track children that are not up-to-date and make radio announcements for follow up. One of the difficulties with immunization is the need for refrigeration making transportation and storage of vaccines to and on the outer and remote islands a barrier to receiving proper and timely immunizations.

Well Baby/Child exams are provided at the State clinics free of charge. Services provided include immunization, health education and counseling including nutrition, injury prevention, safety, assessment and monitoring for growth and development and other underlying health problems, and physical examinations. Referrals for dental care, hearing screening, early intervention services, specialty clinics, and home visits are made based on assessment findings. Teams of physicians and nurses travel to the remote islands to provide screening services.

The Newborn Hearing Screening Program has been successfully screening 92% of our babies before hospital discharge. However, up until this time home births have not been recorded in the denominator of that calculation. Therefore, the total percent of newborns screened for hearing loss is less than reported. The MCH Program intends to increase efforts to screen newborns delivered at home at entry into the health care system. The program has been focusing our quality improvement activities to reduce our loss to follow-up numbers. The EHDI surveillance system, called Family Track, has been instrumental in identifying babies that are not screened for hearing loss and those that do not come back for the second hearing test.

The Dental Program provides services that include general dentistry such as sealant application, fluoride tablets, education/counseling, community outreach activities, cleaning, extraction, and fillings. Oral health for children is focused on prevention through the school sealant and varnish programs. Teams of physicians and nurses travel to the remote islands to provide dental services.

Adolescent Health:
Preventive and primary health care services for adolescents are provided at the State clinics. The adolescent health focus is on the avoidance of risky health behaviors such as drugs, alcohol, and unsafe sex. The MCH Programs works closely with the HIV/STD Program described above. In addition they collaborate with the Behavioral Health and Wellness (BH&W) Program to promote positive youth behaviors. The BH&W Program leads underage drinking prevention efforts. It also addresses injury and suicide, violence prevention and has strong ties to the federal, state and community agencies and programs that carry out risky behavior reduction activities.

Children with Special Health Care Needs:
The CSHCN Program is a component of the MCH Program. Services are set up to promote an integrated service delivery system for CSHCN from birth to 21 years of age and their families. The CSHCN Program works to ensure that children not only receive specialized health care that they need but that they are up-to-date with their immunizations and that they avail themselves, if qualified, of the different social service programs on island. One priority of the program is to identify these children at the earliest age possible, preferably right after birth. There are care coordinators, special education teachers, and occupational, physical, and speech therapists on staff for all CSHCN. The Program works collaboratively and cooperatively with other agencies and departments to provide appropriate education and support services needed to meet their social, emotional, physical, and medical needs. The CSHCN Program has been developed as an interagency effort among the MCH Program, the State Hospital, the Special Education Program, and the Early Childhood Education Program.

Each year a Pediatric Cardiology team travels from the Orange County Children's Hospital in Los Angeles, CA to FSM to provide Pediatric Cardiology Services. This team travels to the four states to follow-up on identified cases and screen for new cases of children with possible heart diseases. The team is comprised of a Cardiologist, an Echo Tech, and a Medical Scribe. Those children who are identified with heart problems and need medical treatment are provided with medicine. For those you need surgery and cannot be done on island are referred to Trippler Army Hospital in Honolulu, HI.

An Audiologist also comes to FSM every year to conduct Diagnostic Audiological Evaluation of those children who failed two out of three hearing screenings. Those children who are confirmed as having hearing loss are either treated, operated on, or referred for Early Intervention services with the Special Education Program.

Specialty teams from Canvassback, Trippler Hospital, and Shriner Children Hospital also visit FSM but at a lesser interval, depending on availability of funds by the FSM Department of Health. These specialized groups provide services in EENT, Orthopedics, and select surgeries. With limited or practically no state-of-the-art medical equipment, compounded with the lack of physicians with specialized skills, FSM is heavily relied on overseas contractors and medical referrals, both of which are very expensive. FSM continues to negotiate with the overseas contractors so "costs" can remain low.

Cross-cutting:
The Dental Program described above provides services for all MCH populations. Teams of physicians and nurses travel to the remote islands to provide dental services. The Tobacco Control Program is available in each State to assist with the initiatives towards reduced tobacco use. However no pharmacological agents are available to aid in tobacco cessation nor is quitting tobacco use with betel nut clearly understood.

II.B.2.b.iii. MCH Workforce Development and Capacity

In 2015 there are 32 full-time staff in the four FSM States funded by the Title V Program. Out of the total (32 employees,) 13 are in Chuuk state; 5 in Kosrae state; 6 in Pohnpei state; and 8 in Yap state. Of the 13 MCH staff in Chuuk state; 4 are staff nurses, 2 are health assistants, 2 are coordinators, 2 are administrative support staffs, 1 is a physician, 1 is a financial staff, and 1 is a dental assistant. Out of the total (5 employees) in Kosrae state; 2 are coordinators, 1 is a staff nurse, 1 is a nutritionist, and 1 is a dental nurse. Of the total (6 staff) in Pohnpei state; 2 are coordinators, 1 is a dental nurse, 1 is a dental assistant, 1 is a staff nurse, and 1 is an administrative assistant. Of the total (8 staff) in Yap state; 3 are dental nurses, 2 are coordinators, 2 are staff nurses, and 1 is an administrative assistant. In addition, there are 4 data specialists funded by the SSDI Program that play integral role in the Title V Program. These specialists physically work in each of the Vital Statistics and Record Divisions of each of the State Hospital. These staff constitute the MCH Programs in each of the State Public Health Departments and they directly

provide all of the preventive and primary health care services at no cost to clients.

The 4 MCH Coordinators, at state level, are responsible for assuring that clinical services are provided to pregnant women, infants, children, and CSHCN. Of the 4 MCH Coordinators, 3 are Registered Nurses and 1 has hospital experience as the Head of the Medical Supplies Department. Of the 3 CSHCN Coordinators, 2 are Registered Nurses and 1 has experience working with the Department of Education, Special Education Program. In addition to these RNs, each of the States provides in its own budget a medical doctor for the MCH Program and together they are responsible for assuring that clinical services are provided.

At the National level, there are 2 full-time equivalent staff paid by the MCH program, they include the Program Coordinator and CSHCN Physician who is based in Chuuk State. She travels to the National Office and the States on as needed basis. The National Family Planning Program Coordinator and financial specialist, although paid for by a different program, also assist the National MCH Program Coordinator in the planning, developing, implementing, and monitoring of MCH program services and activities at the national and state levels on a daily basis. These staff constitutes the core staff at the national level and the National MCH Program Coordinator reports directly to the Secretary of Health and Social Affairs. Please refer to bio-data of national key staff in Attachment #1.

The Chuuk MCH Program hired a parent of a child with special health care needs who served as the CSHCN Program Coordinator for over 10 years and then as the EHDI Program Follow-Up Coordinator for the past 5 years. 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. Often times they are invited as Key Note Speakers to present on selected topics. They also attend national conferences depending upon availability of funds. In September 2013 the FSM Health Department hired an Epidemiologist to serve the needs of FSM to identify causative agents or conditions resulting in adverse health effects, provide data and information concerning corrective actions or programs to alleviate adverse health effects, and propose practices or policies based on findings that will preserve or promote public health and is based in Pohnpei State Hospital and provides valuable information and services including training for the MCH Program staff.

Training and education of the National and State MCH Program Coordinators and staff are carried out at three levels: (1) Individual on-site consultation provided twice a year for the MCH Coordinators and CSHCN Coordinators in the four states on developing policy and procedures, program implementation, data collection, data analysis and interpretation, and improving data capacity; (2) 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 Departments where issues are discussed related to improving services and state data capacity and early intervention services for CSHCN; and (3) Special conferences and other educational opportunities provided to the State MCH Coordinators who attended on-line courses from the Fiji School of Medicine, National and State MCH and CSHCN Coordinators attended the PACRIM Conference in Honolulu, State MCH Physicians attended the Pacific Medical Association Conferences, and MCH nurses attended the American Pacific Nurses Leadership Conference which rotates among the Pacific Islands each year.

The FSM is composed of four different societies with 12 different major languages. These languages are Kosraean in Kosrae; Pohnpeian, Kapingamarangian, Nukuoran, Mortlockese, Mokilese Ngatikese and Pingelapese in Pohnpei; Chuukese and Mortlockese in Chuuk; and Yapese and Ulithian in Yap. 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.

FSM has completed development of the WebMCH Module, a web-based data collection and reporting system adopted from the WebIZ. The WebIZ is a web-based system developed by Envision Technologies and used by the FSM Immunization Program. The WebMCH Module was completed February 2015 and deployed onto the production site June 2015. By December 2015, the System Specialist for the FSM WebIZ will train the FSM National and State MCH Program staff on how to use the system so they can start using the System beginning in January 2016. The WebMCH should improve data collection, reporting, and sharing at State level and between the States and the National level. Because it is a web-based system, the National MCH Coordinator should be able to view data recorded each day at state level, at the same time receive aggregate data recorded by all state programs. This should dramatically improve timely data collection and reporting and improve the overall appearance of the FSM MCH Program.

II.B.2.c. Partnerships, Collaboration, and Coordination

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

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

MCH is also well integrated with Immunization Program, the Substance Abuse and Mental Health Program and the HIV/STD Prevention Program. Again, the efforts and objectives are shared between programs and has allowed for expand staff coverage and program implementation. Through the Immunization Program, the MCH Program in Pohnpei State also collaborates with the Genesis Clinic and the Pohnpei Family Health Clinic (two private clinics in Pohnpei) by providing vaccines free of charge. In return, the clinics provide immunization data.

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

The FSM Dept of Education, in particular the Early Intervention Service, is an essential partner of the CSHCN Program. Together the agencies offer services for children served by the FSM Dept of Education and the Public Health CSHCN Program. A staff member represents the program on each of the state's Inter-Agency Council.

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

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

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

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

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

The MCH Program staff at the state level work closely with parents support groups, church leaders, women's groups, and community and traditional leaders. However, the current use of the parent/consumer partnership is limited. Outside the CSHCN population, the parent/consumer partnership is non-existent at this time. Within the CSHCN population each state has an Inter-Agency Council (IAC) consisting of representatives from Public Health, Special Education, community groups such as churches, NGOs and advocacy bodies, as well as parents and consumers of the CSHCN services. Being that each state has an IAC the diversity of each state's population is represented appropriately. As a group focused on CSHCN, they are educated and aware of CSHCN competencies but not MCH core competencies overall. In Kosrae, the IAC meets monthly and has approximately 20 members, half of which are parents and consumers. The members receive a meeting allowance of $20 per meeting. In Chuuk, the IAC has blended with the duplicative Special Education Board which had the same association objectives and focus. The Special Education Board meets quarterly and has approximately 15 members, half of which are parents or consumers. This board receives no compensation or monetary incentive for participation. In Yap, the IAC is not very active and attempts to meet quarterly but with difficulty. Only one parent serves on the council. In Pohnpei, the IAC has not met for at least two years. Where the IAC is active, parents and consumers have and equal say and equal vote to other members in the business of the council. Council business centers around patient rights, program policies, access issues, and needs and gaps in services provided. The MCH program intends to expand its parent/consumer partnership in the coming years to improve public input into the program and its policies and objectives.

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

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Improve women's health through cervical cancer and anemia screening	New	Increase women receiving a well woman visit including Pap or VIA
2	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care, hearing and anemia screening of the infant and promoting breastfeeding.	Continued	Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9
3	Improve child health through providing vaccinations and screening for developmental delays	Replaced	Increase children receiving developmental screening
4	Reduce childhood injury	New	Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9
5	Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, inj	Continued	Increase adolescents receiving a well visit
6	Provide a transitional services for youth identified as having Special Health Care Needs	New	Increase CSHCN receiving transitional services
7	Improve identification of CSHCN through screening for developmental delays	New	Increase children receiving developmental screening
8	Improve oral health of children	Continued	Increase children receiving a preventative dental visit
9	Reduce tobacco use in pregnant women	New	Decrease percent of women who use tobacco during pregnancy

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

1. Improve women's health through cervical cancer and anemia screening.

2. Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding

3. Improve child health through providing vaccinations and screening for developmental delays.

4. Reduce childhood injury.

5. Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)

6. Provide a transitional services for youth identified as having Special Health Care Needs.

7. Improve identification of CSHCN through screening for developmental delays.

8. Improve oral health of children.

9. Reduce tobacco use in pregnant women

The comparison to prior priorities identified in 2010 is slightly different given the new domains presented by HRSA MCHB. Also, FSM MCH program took a broader view of the priorities to improve overall health through specific actions. The more specific goal based measures (i.e. Increase women reporting exclusive breastfeeding through 6 months) can be seen in the chosen National Performance Measures and State Performance Measures. Below is a table of the old priorities compared to the new with notations of changes.

2010	2015	notes
Increase the percentage of pregnant women attending antenatal care in the first trimester		Replaced
Decrease infant mortality	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding	Continued although combined
Improve the nutritional status of the MCH population		Replaced
Increase the percentage of immunization coverage	Improve child health through providing vaccinations and screening for developmental delays	Replaced and combined to focus on outcome and include immunization as a factor towards that outcome
Decrease incidence of STIs		Replaced

in among the MCH population		
Decrease the rate of teenage pregnancy	Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)	Continued and combined to focus on outcome and include reducing teen pregnancy as a factor towards that outcome
Improve oral health status among the MCH population	Improve oral health of children	Continued although refined
Improve the number of Newborns screened or diagnosed with potential hearing loss for early intervention services	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding	Continued although combined
	Improve women's health through cervical cancer and anemia screening	New
	Reduce childhood injury	New
	Provide a transitional services for youth identified as having Special Health Care Needs	New
	Improve identification of CSHCN through screening for developmental delays	New
	Reduce tobacco use in pregnant women	New

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

FSM assessed the needs of the MCH population using Title V indicators, performance measures and other quantitative and qualitative data. The Steering Committee reviewed major morbidity, mortality, health problems, gaps and disparities for the MCH population in order to identify specific needs by MCH population domain based on analysis of data trends. The cross-cutting needs were also examined. The Steering Committee spent several sessions determining data needs and gaps, and reviewing data findings.

Specially, the Steering Committee:

- Reviewed the 2010 Needs Assessment and interim needs assessment findings and noted trends since the last assessment;
- Reviewed recent state, regional and national reports to determine possible issues/problems to be explored in the FSM;
- Reviewed recommendations made by various task forces;
- Identified major data/indicators (including trends) of health status, access, health needs and health disparities to be included in the assessment for each domain; and
- Determined stakeholder and public input processes.

Quantitative methods used for assessing needs for each of the population domains included a review of various the data sources including Vital Statistics Data, Census Data for the FSM, Surveillance Systems and Registries, Mortality Reviews, and other FSM Agency Data and Reports. The Steering Committee developed a set of MCH indicators to guide this phase of the work. Findings were also used to populate the MCH Priority Health Issues Survey.

Qualitative methods included the use of the aforementioned survey to MCH clients, stakeholders (described below in Stakeholders), parents and community members. MCH received 130 completed surveys covering the six domains. Survey participants chose their top five issues for each domain, while also identifying any important issues not reflected in the original list. Of the new issues identified, most had been considered by the Steering Committee in earlier phases of the needs assessment process. In addition, qualitative data was a review of state plans and reports prepared since the last needs assessment.

At the end of the above process, results were summarized from all activities and presented to the Steering Committee. As expected, the focus areas identified across approaches overlapped due to the impact that many of the issues exert throughout the life course. This phase concluded with the identification of 21 potential MCH priorities spanning the six domains. The Steering Committee met concerning the potential priorities identified with the goal of further refining and prioritizing the issues.

Prioritization criteria included considering potential issues 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 (S.W.O.T.) 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.

- Structural Resources: Financial, human, and material resources; policies and protocols; and other resources needed for the performance of core functions.
- 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.
- Competencies/Skills: Knowledge, skills, and abilities of MCH staff.

- Organizational Relationships: Partnerships, communication channels, and other types of interactions and collaborations with public and private entities.

This phase concluded with the reduction to 15 potential MCH priorities spanning the six domains.

Next was the final prioritization process and state capacity assessment to determine the MCH priorities for FY2016-2020 and in keeping with the guiding principles of the process, the Steering Committee focused on the goal of identifying select areas for MCH investment, so that a comprehensive set of interventions could be employed at more depth to affect five-year outcomes. In addition, the chosen priorities needed to be tied to the MCH scope of influence in order to assure ultimate impact. In order to do so, the Steering Committee was charged with connecting each potential priority to a national or population-based outcome measure. To this end, the Steering Committee prepared a justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period. Following these discussions, each issue was ranked, using a grid specifying impact and feasibility along an x and y axis. This, along with the assessment of state capacity, served as key resources for discussion in determining the final set of nine priorities.

One example of a priority that was discussed but not included in the final list is increasing the number of children age 5-21 years old screened for Rheumatic Fever. Although discussed as a possible issue it was found that this is routinely being done during well visits for this age group. Because of the awareness and success of this initiative, it was determined that other areas took priority in the needs of the FSM MCH population.

Reevaluation every 12 months for children with special health care needs is another priority that was discussed but not chosen. Although this is important and worthwhile, at this time it is unrealistic to pursue. As discussed in the needs assessment the CSHCN Program currently lack the capacity to identify their population except through Special Education. As such, the Steering Committee felt it was a greater priority to build the foundation of independently identifying and tracking the CSHCN population before instituting a change to their reassessment services which are currently being performed mostly through Special Education.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.0	30.0	40.0	50.0	60.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	73.0	75.0	80.0	85.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	73.0	75.0	80.0	85.0

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	12.0	15.0	17.0	20.0

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	320.0	310.0	300.0	280.0	270.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	48.0	50.0	52.0	55.0	58.0

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.0	27.0	30.0	33.0	35.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	47.0	50.0	53.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	47.0	50.0	53.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	0.7	0.5	0.3	0.1	0.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	0.7	0.5	0.3	0.1	0.0

The FSM selected the following eight (8) National Performance Measures in relation to the identified priority areas.

National Performance Measure by Domain	Selected Priority
Women's/Maternal Health	
#1. Increase women receiving a well woman visit including Pap or VIA	Improve women's health through cervical cancer and anemia screening
Infant/Perinatal Health	
#4. Increase women reporting exclusive breastfeeding through 6 months	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding
Children's Health	
#6. Increase children receiving developmental screening	Improve child health through providing vaccinations and screening for developmental delays
#7. Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9	Reduce childhood injury
Adolescent Health	
#10. Increase adolescents receiving a well visit	Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)
Children with Special Health Care Needs	
#12. Increase CSHCN receiving transitional services	Provide a transitional services for youth identified as having Special Health Care Needs
To be accomplished through NPM #6	Improve identification of CSHCN through screening for developmental delays
Cross-Cutting	
#13. Increase children receiving a preventative dental visit	Improve oral health of children
#14. Decrease percent of women who use tobacco during pregnancy	Reduce tobacco use in pregnant women

As apparent from the above table some of the component of the selected priority areas will be covered through the State Performance Measures (please see Section E below).

The National Outcome Measures associated with each identified priority area is described in the table below.

National Outcome Measure by Domain
Women's/Maternal Health
Low birth weight rate (%)
Preterm birth rate (%)
Infant/Perinatal Health
Infant mortality rate per 1,000 live births
Postneonatal mortality rate per 1,000 live births
Children's Health
Percent of children meeting the criteria developed for school readiness
Child mortality ages 1 through 9 per 100,000
Adolescent Health
Adolescent mortality ages 10 through 19 per 100,000
Adolescent motor vehicle mortality ages 15 through 19 per 100,000
Adolescent suicide ages 15 through 19 per 100,000
Children with Special Health Care Needs
Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations
Cross-Cutting
Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

The above measures were selected because of their relationship and proximity to the priorities that were identified as part of the needs assessment.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

E. Link State Selected Priorities with State Performance Measures

The FSM selected the following five (5) State Performance Measures in relation to the identified priority areas.

State Performance Measure	Selected Priority
Increase children receiving routine vaccines	Improve child health through providing vaccinations and screening for developmental delays
Increase women and infants screened for anemia	Improve women's health through cervical cancer and anemia screening; Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding
Increase pregnant women screened for Gestational Diabetes	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding
Reduce infant/fetal death	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding
Increase newborns screened for hearing	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

Please refer to the next page to view the State Action Plan Table in a landscape page orientation.

State Action Plan Table

State: Federated States of Micronesia

Domain	State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	Evidenced-Based or – Informed Strategy Measures	State Performance Measures
Women/Maternal Health	Improve women's health through cervical cancer and anemia screening	1.By 2020 the percentage of women screened for cervical cancer(pap/via) would be increased by 5% 2. 1 By 2018 the percentage of anemia in child bearing age women (15-44) would be decreased by at least 3-5% 3. By 2018 the percentage of anemia in child bearing age women (15-44) would be decreased by at least 3-5%	1a. Provide awareness & education on cancer screening resources 1b. Increase skills and knowledge of health providers re- pap/via 2a. Public awareness on benefits on good nutrition 2b. Follow Approved national standard of practice under diet and obesity 3a. Public awareness on benefits on good nutrition 3b. Follow Approved national standard of practice under diet and obesity		#1. Increase women receiving a well woman visit including Pap or VIA		Increase women and infants screened for anemia
Perinatal Infant Health	Improve perinatal/infant	1.By October 31, 2015. Review the	1a.Educate the staffs, physician, and policy		#4. Reduce rate of		Increase pregnant women

	outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care services, hearing and anemia screening of the infant and promoting breastfeeding	antenatal Policy/Procedures to include screening for Gestational Diabetes Millitus (GDM) with Glucose Tolerance Test (GTT). 2.By January 2016, procurement of GTT supplies are available in all four States 3.By October 1, revised and improve data collection to include GDM 4. *By the end of fiscal year 2016, 85% of all newborns will be screened for hearing* 5. *By the end of FY 2016, at least 5 staffs from OB ward and MCH to be trained on how to conduct hearing screening* *6.* By the end of 2017, increased by	makers to be more aware of GDM. 1b.Upgrade skills for public health staff by doing training on GTT 2.Inventory and reordering of 50 gram and other screening supplies needed 3.Educational awareness to health providers and community 4a. Screen all newborns before hospital discharge 4b. Conduct hearing at well baby clinic at Public Health 4c. Physicians at the hospital to refer infants who missed initial screening to be screened at well baby clinic 4d.Health Assistants and Midwives at the community health centers and outer island dispensaries to refer home births infants to WBC to be		hospitalization for non-fatal injury per 100,000 children ages 0 through 9		screened for Gestational Diabetes Reduce infant/fetal death Increase newborns screened for hearing

		5% from the baseline (FSM) the number of mothers who exclusively breastfeed their infants up to 6 months. 7. By 2015, FSM MCH to adopt the World Breastfeeding Trend Initiative (WBTI) 8. By the end of FY 2016, there will be an increase number of 1 year old children screened for Anemia by 5% 9. By the end of FY 2016, there will be a decreased number of 1 year old children with anemia by 5% **10.** : By the end of 2017, increased by 5% from the baseline (FSM) the number of mothers who exclusively breastfeed their infants up to 6	screened 4e. EHDI staffs to conduct home bound screening to infants unable to come to the hospital for screening 4f. Conduct community awareness on the importance of hearing screening 4g. Conduct awareness on the importance of hearing test to pregnant women who come for their prenatal visit 4h. Infants born at the privates clinics to be referred for screening at WBC 5a. EHDI and CSHCN coordinator will train OB and MCH nurses in hearing screening 5b. Conduct update training if new machine available 5c. EHDI and CSHCN coordinator will train OB and MCH nurses in hearing screening, Conduct update					

		months.	training if new machine available 6a. Do full breast feeding campaign twice a year 6b. Establish and reactivate breast feeding support groups 6c. educate support group and health staff on breastfeeding policies to ensure adherence 7a. Community awareness on the WBTI 7b. Training of trainers on WBTI in all states 7c. Develop a implementation plan 8a. To promote education awareness on the importance of hemoglobin screening among 1 year old 8b. improve accessibility of services in communities and outer islands 9a. To promote education awareness					

			on good nutrition for 1year old children 9b. Improve Availability of services and treatment in the communities 9c. Collaborate with other agencies to support promotion of good nutrition **10.a** evaluate and monitor effectiveness of the campaign through *surveys*				
Child Health	1. Improve child health through providing vaccinations and screening	1a. By the end of FY 2016, increase of immunization coverage among 2 years old by 5%. 1b. By the end of	1a.1. to promote education awareness on the importance of immunization in communities 1a.2. accessibility of Immunization services		#6.Increase children receiving developmental screening #7. Reduce rate of		Increase children receiving routine vaccines

	for developmental delay 2. Reduce childhood injury	FY16, developmental screening for children ages 1-6 years of age will be increased by 20% from previous year ***1c.*** By the end of FY 2016, 10 staffs from Department of Health Services and Education will be trained on how to conduct or provide developmental screening and evaluation to children ages 1-6 2.Quarterly parental and community awareness of common cause of childhood injury and its prevention 3.By December 2015, to enhance collaboration with Public Safety, NGOs and group raising community awareness of child injury prevention	on the island and remote islands. 1b.1. Continue developmental screening and evaluation of 1 year old at WBC 1b.2. Develop screening tools for 2-6 years old 1b.3. Strengthen Child Find with Special Education and Early childhood education for children ages from 0-5 years old 1b.4. Community awareness on the importance of developmental screening 1c.1. Staffs from Special Education and Health Services who provide developmental screening and evaluation will train Health Assistants, CSHCN staffs, MCH staffs and other NGO health center staffs on how to provide developmental		hospitalization for non-fatal injury per 100,000 children ages 0 through 9			

			screening and evaluation 2a.To do parental and community education campaign using visual aid, radio, television, posters in prominent areas in the community 2b.To increase injury prevention education during well baby clinics 2c.Educational awareness on safety in the school. 3.To establish better communications among the Public Health, Public Safety, DOE and NGOs regarding child injury prevention				
CSHCN	1. Provide a transitional services for youth identified as having	1A. To evaluate MCH capacity for transition service 1B. To enhance existing	1a.1. Review and update current policies and protocols for transition services 1a.2. Evaluate the need for staff to		#12. Increase CSHCN receiving transitional services		

	Special Health Care Needs 2. 2. Improve identification of CSHCN through screening for developmental delays	collaboration with Department of Health Services and organizations/groups that aid in providing transition services. 2.By the end of FY16, developmental screening for children ages 1-6 years of age will be increased by 20% from previous year ***3.*** By the end of FY 2016, 10 staffs from Department of Health Services and Education will be trained on how to conduct or provide developmental screening and evaluation to children ages 1-6	provide transition services 1a.3. Do training for new and current staff to improve provision of transition services 1b.1. Schedule regular interagency organization meetings with other agencies/organization 1b.2. Enhance education for parents/relatives and improve collaboration among parents/relatives. 2a. Continue developmental screening and evaluation of 1 year old at WBC 2b. Develop screening tools for 2-6 years old 2c. Strengthen Child Find with Special Education and Early childhood education for children ages from 0-5 years old 2d.Community					

			awareness on the importance of developmental screening 3a. Staffs from Special Education and Health Services who provide developmental screening and evaluation will train Health Assistants, CSHCN staffs, MCH staffs and other NGO health center staffs on how to provide developmental screening and evaluation				
Adolescent Health	Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, injury, suicide)	1. by the end of FY 2016, increased awareness (quarterly awareness) on healthy lifestyle among youth age 12-17 years old.	1a. to increase education awareness on teenage pregnancy, STDs, drug, alcohol and tobacco use. in schools and communities 1b. Accessibility of SRH services in schools and communities 1c. To adopt WHO		#10. Increase adolescents receiving a well visit		

			iron supplement initiative				
Cross-Cutting or Life Course	1. Improve oral health of children 2. Reduce tobacco use in pregnant women	1.Educate mothers on the importance of oral health in children 2.Improve dental practice and services 3.Improve interagency collaboration among MCH Program, Dental Division, the Community and Outer island dispensaries	1a. Provide educational brochures/pamphlets to mothers during ANC & WBC (2 wks) 1b. Community & Clinical outreach 1c. Nutrition & Oral Hygiene education during special clinics and community visits 2a. Provide toothbrush and toothpaste during WBC (6 months & 1 Year) 2b. Continue providing fluoride varnish and sealant 3a. Create uniform tracking/reporting system		#13. Increase children receiving a preventative dental visit #14. Decrease percent of women who use tobacco during pregnancy		

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

The FSM MCH Program will continue to do Pap smear as the primary method of screening for cervical cancer. It is a plan for the Program to renew the Pap smear Contract with LabTech for next year and to continue using CTSI to ship these Pap smears specimen to the LabTech in Guam. FSM is working toward increasing the number of women of childbearing age screened for cervical cancer through Pap smear screening by collaborating with the other public health programs in the coming year. The Program will work with the respective state health departments and public health programs to modify their clinic schedules by allowing walk-ins and extending the prenatal clinics time to accommodate those working mothers or women who cannot come at the assigned clinic time. FSM MCH Program will continue working effortlessly with the respective state health departments and other public health programs to lessen the patient's waiting time by bringing all preventive services in one single location, preferably at the Public Health Services. While consolidating the services in a "one-shop" type services, MCH programs will continue to partner with community partnerships and NGOs to assist in dissemination of information regarding health educational and community awareness on cervical cancer prevention. The FSM MCH Program will continue to work closely with the State Health Departments and other public health programs to support the services for women and mothers to provide funding to purchase additional and sufficient needed medical equipment and supplies. The FSM MCH Program is continuing working very closely with other regional and international donor-partners such as UNFPA, UNICEP and WHO to support these services for women. These additional supports from the international partners are mainly the seeking and securing of funding and procurement of necessary equipment and supplies for Essential Obstetrics Care for all the clinics in FSM. FSM MCH Program will continue doing all efforts to increase the rate of women with childbearing age (including pregnant women) screened for anemia, and receiving proper treatment, in all public health clinics throughout all the four (4) States in FSM during this project period.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20	30	40	50	60

Every clinic within the FSM Department of Health, Division of Public Health, do series of preventive measures including health examination for women. FSM Data showed that in 2014, there were 5,461 women receiving MCH program services. Out of the total received services, 17% (887 out of 5,461) had Pap smear done (screened). Of those screened, 3.0% (27 out of 887) had Pap smears resulted positive. In 2013, it showed a total of 10,309 women receiving MCH services and out of the 10,309 MCH users, 8% (788 out of 10,309) had Pap smear (screened). Out of the total screened, 3% (19 out of 788) were with positive Pap smear results. Although the data showed a slight increase in the percentage of women screened (8% in 2013 vs. 17% in 2014), it is worthy to note that the number of women utilizing the services dropped almost 50% from 10,309 in 2013 to 5,461 in 2014. However, it is also important to point out that the percentage of "positives" remains the same number (3%) for the 2 consecutive years regardless of their denominators. High rate of vaginal and cervical infections in women, inaccessibility of Pap smear services (only done at the hospital facilities), clinic schedules, and shortage of skilled staff remained the major causes for the continued low screened rate. These women with vaginal and cervical infections were given treatment

on site and an appointment to come back after a week or two (depending on the course of their treatment), at which many of them do not return. While VIA (Visual Inspection with Acetic Acid) is not an uniform activity throughout FSM, it is important to note that (2 States) Pohnpei and Yap do VIA as an alternative to Pap Smear testing in those areas where pap smear cannot be done. This piece of information is not reflected in the data below. As much as efforts for awareness and Pap smear screening are done, FSM still has a large population of underserved women of childbearing age in the communities who are not receiving the recommended annual preventive health care services. Like many unreached and underserved communities, the percentage of families living below the federal poverty level is high. These are the marginalized group of women who face many barriers to receive adequate and proper health care. These barriers are including but not limited to; poor awareness of their health needs, Shame of their economical or living status that they fear seeking reproductive health services, poor access to health care services and/or information, no Insurance to cover health care costs, transportation issues, Childcare issues (too many children with none or little help), etc. The FSM Maternal and Child Health clinics are the medical home for the many women that have their first entry into medical care service. MCH Program is providing services and making recommendations on preventive health care services in accordance with the nationally 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 increase education and outreach efforts in strong collaboration with community-based programs. FSM has an advantage of having all the preventive services housed under one roof in public health, clients or service users can receive multiple preventive health screening and services in one visit. This unique set up makes The MCH Program serves as the gateway to care through partnerships with other public health programs. The MCH Program works very closely with the Family Planning Program, Tobacco Control Program, STD/HIV Prevention Program, Immunization Program, Community-based Organizations (Women, Youth and Faiths), and other health and social programs. MCH Program is working with these other public health programs to ensure that services and care are comprehensive and coordinated to minimize the number of visits that is needed for one client. An assessment of prenatal care conducted at the state hospitals in the FSM showed that in 2014 only 9% of women received adequate prenatal care based on the Kotelchuck Index. This data showed a tremendous drop by 24% from 2013 where it was 32.6%. The causes of the tremendous decrease include inaccessibility of services (prenatal care still not yet decentralized in many places), direct and indirect cost of transportation, clinic waiting time, priority over family daily income, cultural barriers that makes some women avoid such examinations or screening (Pap smears, pelvic exam, HIV/AIDS and STDs), cultural beliefs of pregnancy in terms of waiting until deliver to before doing all routines or rituals (don't count the chickens before they hatch), fear of miscarriages so they waiting until fetus is viable to make any trips (no strenuous activity for the first trimester), and the clinic procedures and requirements that resulted in several stops (interview, pre-counseling, dental, HIV/STD, SAMH, Laboratory) before being seen by the doctors. Prenatal Check is not considered a top priority for many pregnant women or families as long as they feel healthy in their own belief. Additionally, some states reported that 10% of deliveries are from women with no prenatal care at all. The FSM MCH Program plans to continue to strive for improvement in adequate prenatal care by doing more sessions and expanding health education in the schools (targeting the young teens who will become parents one day) and communities (parents, caregivers and youths) on the importance of early and adequate prenatal care in conjunction with a good birth outcome. 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. With such, some women may have difficulty fitting into their schedules working schedules as well as only limited number of women may have be available on these particular days. This may also mean that there is a much longer waiting time during a clinic as well as over crowdedness in limited waiting area. Besides the waiting time, the process of being seen is long since there are few steps and things needed to be done in one visit. In some states, the woman checks in at one location, see the provider at a different location, go to other locations for laboratory works and then another one for dental check-up. Streamlining the process is an aim for MCH program to improve and increase prenatal care attendance. Our 2014 data shows that only 22% (426 out of 1,957 live births) of the births are those who received antenatal care during the first trimester. This is not much of a difference for 2013 where the data showed 23.6%. According to the Antenatal Care survey in Chuuk, long waiting time and transportation were the two top reasons for women not

coming early to receive prenatal care. However, amongst those women seeking and receiving prenatal care, there is still the issue on adequacy. Some clinics sites in Pohnpei, they lack the basic and proper tools for prenatal service like Doppler and ultrasounds. Others states lack basic supplies as fetoscopes, prenatal vitamins, glucometers and urine dipsticks (mainly in Chuuk) thereby limiting the diagnostic capabilities of the prenatal care services. There is limited education in the community resulting in poor awareness on what are expected during pregnancy (at prenatal care) and during deliveries (at delivery sites). Diabetes screening during pregnancy is not routine in all the FSM States so screening for Gestational Diabetes is not currently done except in the State of Yap. In Pohnpei, screening is not done at all although the lab possesses the capabilities. Kosrae and Chuuk do screening only based on risks (known history of diabetes, family history of DM, history of big babies and stillbirth, or previous history of gestational diabetes). According to pediatric providers in the FSM, many infants born with difficulty controlling their blood sugar within the first 48 hours of birth, a telltale sign of missed or poorly control gestational diabetes. As a measure to improve the adequacy of prenatal care and improve fetal outcomes, the FSM MCH Program plans to implement GTT (glucose tolerance test) as a routine care and procedures in all prenatal care clinics. In 2010, the FSM MCH Program noticed an increase number of anemia in women, diagnosed during pregnancy. In an effort to increase a woman's health status prior to pregnancy the program instituted screening all women of childbearing age for anemia anytime being encountered by MCH services but not just during pregnancy. There are more efforts done in 2014 regarding this activity and it resulted in an increase in the number of women of childbearing age screened for anemia compared compare to the previous years. A total of 19.5% screened for anemia in 2014 vs. an 11.9% in 2013. With the number of screened increases, the number with anemia cases also increases. Whether the increase in actual anemia cases is due to more screens versus more anemic is not clear at this point and will need more efforts and activities to be proven. Anemia screening and treatment is still a necessary measure of all women in the FSM.

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

The FSM MCH Program is committed to improve prenatal care access and adequacy through the MCH clinics and dispensaries in the outlying and remote villages. Improving prenatal care and access would improve birth outcomes especially during the perinatal and neonatal periods. Accessing a proper and adequate care will play a significant role in improving birth outcomes and lessen babies that are born with low and very low birth weights. FSM MCH Program plans to request additional funds to purchase needed equipment and supplies to facilitate accessibility of prenatal care service at the community levels. Screening for gestational diabetes as a routine for prenatal care services will be implemented and enforced in all four (4) FSM States. Exclusive Breastfeeding will continued being enforced and encouraged for all mothers. Educational awareness on breastfeeding and infant nutrition will be in full force most especially with the new mothers (parents) and primary care givers. Due to the high prevalence of anemia in infants, FSM MCH Program will continue screening all one year olds for anemia in the clinics. To capture those infants that do not utilize the services, FSM-MCH Program is seeking funding to procure 4 hemoCue machines to expanding the screening out to schools and communities. Program procedures and manuals will be in place for obtaining specimen and treatment of anemia in children and childbearing age. Women of childbearing age will continue to be screened and treated for anemia as well to reduce the number of anemia in pregnant women hence improve their health and birth outcomes.

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	73.0	75.0	80.0	85.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	73.0	75.0	80.0	85.0

The perinatal mortality rate in the FSM in 2014 is 37.2 per 1,000 live births. This is a decrease of 2% from previous year (2013) where it has 39.0 per 1,000 live births. Although the data reported a slight decrease, this is still considered high per recommended target. Based on reports received from the State MCH Programs, more infants are dying during the first week of life. The cause of deaths reported includes; RDS (respiratory distress syndrome) from prematurity, asphyxia due to prolonged 2nd stage of labor, multiple congenital abnormalities, meningitis, and pneumonia. According to the National Vital Statistics Reports, the most recent national perinatal mortality rate available was 6.26 per 1,000 live births in 2011. When this data is paired with the 2014 low birth weight percentage of 11% (live singleton births), a picture of unplanned pregnancy, late access to care, inadequate prenatal care, and poverty can be clearly seen. All these factors play significant roles in the poor birth outcomes causing additional stresses on the family, community, the health care system and the government. Lack of screening for gestational

diabetes during prenatal care effects birth outcomes and newborn care. Although the 2014 data showed 67.6% of mothers in FSM exclusive breastfeed their babies at six months old, the adequacy of breastfeeding has not been fully assessed. The qualitative reports from some pediatric providers showed that some mothers supplementing their breast milk with other supplements like water and coconut juice. This is mainly true in areas where cultural practiced supersedes the medical advice. Even more so, this kind of practices can harm the babies more than it does any good. This more reason why more awareness and health education on breastfeeding and infant nutrition need to be provided at all levels of care. Childcare education needs to be a forefront subject in educational curriculum in the FSM. New mothers rely on experienced family elders to teach them about child care and child rearing. Many times, this can be misleading and may not be the healthiest or safest method at all. In 2013, 78.7% of mothers exclusively breastfeed their children at six months of age. The decrease in number of exclusive breastfeeding at six months of age in 2014 may be the result of poor data collection. The FSM National MCH Program is confident that data collection and reporting will be improved once the WebMCH Module is activated in early 2016. Anemia is prevalent in the infant and childbearing age population in FSM. In 2014, 35.2% of 1 year old screened for anemia had hematocrit below 35mg%, a cutoff mark use for diagnosing anemia. This 2014 percentage of 35.2% is a slight decrease compared to 45% in 2013. However, the number of 1 year old screened for anemia in 2014 increases by 5 %(16.6%) compared to the 11/1% in 2013. This data is taken from the Well-Baby Clinics but not all the 1 year olds attending Well Baby clinics had their screening. For the Childbearing age group, 19.5% are found to be anemic in 2014 compared to 11.9% in 2013. This is an increased by 8%. Again, the issue of whether or not more anemic vs. more screens need to be clearly identified.

Child Health

Child Health - Plan for the Application Year

FSM MCH Program plans to improve immunizations next year through more community and parental educational awareness on the importance of immunization. For the states that have scattered and outlying islands (Chuuk, Yap and Pohnpei), increase number of outreach visits will be a top priority in 2016. The FSM MCH Program plans to seek additional funding from the National Immunization Program and the Sector (compact) funds to support purchasing of sufficient fuel for the proposed increased number of outreach services for the outer and neighboring islands in the next years. As a vital component of the community and parental education, MCH Program will promote safety at all levels of children's environment. Parents, schools, and communities will be educated on safe, secure and protected places for children. This is an attempt by the MCH Program to reduce child injury, one of the major causes of poor health and disabling conditions in the children age group. The FSM MCH Program will work with the State and Local government to ensure safe areas that are designated and accessible and serve as an appropriate playground for children in all the four (4) FSM States. The FSM MCH Program will continue collaborating and working closely with the FSM Department of Education, Division of Special Education, to strengthen the Child Find Program so more children can be screened for any developmental delays and receive appropriate interventions. The FSM MCH Program will continue to work with the Special Education Program to identify and develop a national screening tool for both service providers and parents to use for early identification of all children not developing accordingly. The FSM MCH Program will continue working with and contracting overseas specialist in cardiology, audiology and other specialty areas that are not available in FSM. The FSM MCH Program will continue working with Special Education Program, Related Services Assistants (RSA) to provide education and support services to the children and parents of children with hearing loss until being evaluated by an audiologist. This is to avoid any gaps in providing the needed and special care for these children. The MCH program plans to extend the screening age to six (6) years old through the development of age-appropriate screening tools in an effort to increase screening for all children. FSM MCH Program plans to work with the Chuuk and Yap State Law Makers so they can also pass legislations mandating Newborn Hearing Screening.

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10	12	15	17	20

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	320	310	300	280	270

Immunization is one of the pillars in child health care services. However, the overall immunization coverage for

children 2 years old in FSM is quiet low. In 2014, the FSM Immunization Program reported that 75.5% of all children through age 2 have completed routine immunizations. This is a notable increase from 59.2% in 2013, an increase by 17%. Activities that contributed to the increase as reported by the FSM State MCH Programs included; MMR Campaigns, increased involvement by dispensaries and other public health programs in doing vaccinations during their program visits, and support from NGOs. There is more media involvement; health education and awareness program on the local T.V. channel, radio spots, and relentless dissemination of IEC materials in the clinics and communities. Additional funding was provided by the FSM Immunization program and Sector Funds which added to the success of the program services. One of the main barriers for immunizations in the FSM is the need for refrigeration of the vaccines. This in itself hindered the provision of the vaccines in the outer islands, therefore, not reaching every child. This is apparent in the data specific for Kosrae, a single island State with no outer islands, has a 2014 immunization coverage of 90.7%. In Pohnpei, outreach services to the outer islands are only done once or twice a year. However, in Chuuk and Yap, the schedule is not reliable and often dependent on availability of the big cargo ships and/or availability of fuel to cover the vast number of outlying islands in one trip. Child injury data showed that FSM children experience many non-fatal injuries. It is reported that most of these injuries are falls related to play and drowning related to babies being cared by young care givers. FSM children enjoyed playing in their own natural island ways where it involve jungle racing, climbing trees and rocky cliffs, running barefooted on the sharp coral reefs or rocky areas, and many locally invented games that seemed risky and dangers to many. There are no neighborhood playgrounds offering safe play areas. Non-Fatal injuries are common among children 14 years old and younger. The 2014 data that there were 137 children had injury due to falling compared to 241injury in 2013. Currently, developmental screening are routinely done only on births to 18months old babies unless any indications given for any older age group given that the current screening tool covered only up to 18 months old. No standardized tool exists beyond that age group. In 2014, 99 (5.5%) children were identified with developmental problems and admitted into the CSHCN Program compared to 155 (9.4%) children in 2013. According to State MCH programs, this is an improvement in the health outcome of these babies that there are fewer babies with developmental delays seen. They believe this improvement is due to more parental knowledge and awareness on the importance of avoiding risky behaviors, knowing the norms of normal developmental stages, and proper parental care. Interventions for those with developmental delays do not begin until age 3 with Special Education Program, therefore the MCH program provides the needed care and services for these children and parents. FSM does not have Pediatric Cardiologists, Audiologists, and other specialists and heavily rely on overseas contracts for specialty services. Overseas contracts are not sustainable as they are becoming more and more expensive each year. In 2014, 77.5% of all hospital births had hearing screening prior to hospital discharge. This is a decrease from 92% in 2013. The State MCH Programs reported that some States have problems with their screening equipment (OAEs) and they had to be shipped to the supplier for repair. In some cases, some children are not medically fit to be screened. 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 a visit by an Audiologist. While FSM awaits the arrival of the Audiologist, the MCH/CSHCN and Special Education Related Services Assistants (RSA), in the interim, 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. Those children who are diagnosed with hearing loss are referred for early intervention. Medical and surgical intervention are not done locally bur overseas. In 2014, 6 children were diagnosed with hearing loss and 3 cases were confirm and referred for early intervention (EI). Pohnpei and Kosrae States have passed Legislations mandating Newborn Hearing Screening while Chuuk and Yap States have not.

Adolescent Health

Adolescent Health - Plan for the Application Year

Teenage birth rate is very high in the FSM. For such, the FSM MCH Program plans to continue working closely with the FSM Family Planning Programs and Department of Education to strengthen and improve the services provided at each Adolescence Health Clinics located at the public high schools in Chuuk and Pohnpei (the 2 most populous states), and at the national and state college campuses. This effort is made specifically to prevent the high rate of teen pregnancy. The age of consent for marriage in FSM is 13 years old. With the support of Chuuk Women Council, Chuuk State has passed a law to increase the age of consent for marriage to 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 to increase the age of consent to 18 years of age in the remaining states in FSM. The FSM MCH Program plans to strengthen its partnership with the Family Planning Program,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. The FSM MCH Program plans to expand these school physicals into the high school grades. During these well adolescent visits, youth will receive information and education on risky behavior and its possible negative outcomes.

Adolescent Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	48	50	52	55	58

The FSM teen birth rate for 2014 was 43.6 births per 1,000 females, an increase from 22.4 births per 1,000 females reported in 2013. Although the data is showing a decrease, it is still greater than the national average of 14.1 in 2012 per CDC Morbidity and Mortality weekly report. In a study of maternal, pregnancy, and birth characteristics of Asians and Native Hawaiians/Pacific Islanders, Native Hawaiians/Pacific Islanders were significantly more (four times as) likely to be adolescents aged 15-17 years. This can be seen in the FSM 15-17 year old birth rate. This rate is an important age distinction due to the cultural norm to bear children at a young age. In Pohnpei, there is no marriage age law. In Yap, the legal age of consent is 13 years old. This past year, Chuuk increased the legal age of consent from 13 to 18 years old. Teen births increase health risks to both mother and child including low birth weight, preterm birth, and death in infancy. In addition to health risks teen births set up a cycle of disadvantages. Teen mothers are less likely to finish high school and their children are more likely to have low school achievement, drop out of high school, and give birth themselves as teens. High-risk sexual behaviors among adolescents account for increasing rates of premature morbidity and mortality by contributing to risk of unintended teen pregnancy, HIV/AIDS, and other sexually transmitted diseases. Complications associated with adolescents' sexual risk behaviors may take years to manifest and may seriously compromise adolescents' health and quality of life in adulthood. Cultural and socioeconomic factors may influence high-risk sexual behaviors, which may, in turn, increase risk for HIV/AIDS, other STDs, and unintended pregnancy. The rate of sexually transmitted diseases (STDs) in the FSM is improving. However with limited testing due to financial and laboratory constraints, the rates of Chlamydia may be under reported. In 2014, 77 or 13.8 per 1,000 women aged 15 to 19 reported to have a case of Chlamydia compared to 76

or 7.3 per 1,000 women aged 15 to 19 reported in 2013. Also, in 2014, 241 or 9.2 per 1,000 women aged 20 to 44 reported to have a case of chlamydia compared to 211 or 6.5 per 1,000 reported in 2013. Based on the data provided, and contrary to popular opinion, the data showed that the older women group has more cases of chlamydia. The MCH Program is currently working with youth groups in each State to reach the adolescent population. Such groups are Youth for Change, 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. Risky adolescent behavior such as drug and alcohol use lead to injury such as motor vehicle crashes. Although not much data exists on current drug and alcohol use, it is believed throughout the community that the use does exist and influences poor outcomes. There is lack of law enforcement surrounding alcohol sales and many businesses in the FSM sell alcohol cheap and to youth. In 2014, 9 or 24.2 per 100,000 youths 14 years and younger reported to have been injured due to motor vehicle crashes compared to 10 or 23.6 per 100,000 children injured in 2013. Of the older age group (15 through 24 years) in 2014, 20 or 96 per 100,000 children reported to have been injured due to motor vehicle crashes compared to 6 or 28.3 per 100,000 reported for 2013. Teen suicide is an issue in FSM. In 2014 there were 7 suicides among youths aged 15 through 19 reported and 1 suicide among the same age group in 2013. Chuuk and Pohnpei reported 3 cases each, yap 1 case and Kosrae no case. More awareness and education around suicide, its causes and prevention is necessary in the FSM. Currently the FSM MCH program provides school physicals until age 12.This has to be expanded to high school grades.

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

The FSM MCH Program plans to start using the Web-MCH Module beginning in January 2016 to improve the system to report, tract or register a child as one with special health care needs. The FSM Web-MCH developed by Envision Technologies was completed and deployed into the production site in June this year (2015). The FSM National MCH Program plans to complete User training by December 2015 and begin using the System in January 2016.The FSM MCH Program also plan to continue working close with the Special Education Child Find Program and also plan to develop meaningful transition programs including employment opportunities and recruitment for CSHCNs. During the week of August 3-7, 2015 FSM will have its biennial Interagency Conference in Kosrae State. One of the expected outcomes of the interagency conference this year is the review and updating of the existing MOU between FSM Education, Special Education Program and FSM Health Maternal and Child Health program to include provisions for the newborn hearing (EHDI) program particularly Early Intervention Services for children who have failed a second (follow-up) hearing screening and waiting for an Audiologist to confirm the case and before the case is accepted by the special education program and an IEP is developed.

Children with Special Health Care Needs - Annual Report

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23	27	30	33	35

The FSM MCH Program has a web-based data system to record and report data for MCH program services including services for Children with Special Health Care Needs (CSHCNs). The WebMCH, as the system is referred to, was developed by Envision Technologies, Inc., and completed in February this year, upgraded and deployed to the production site in June this year (2015). User Training is expected to be completed no later than December this year and plans are in place to put the system to use beginning in January 2016. The System will be used by the National MCH Program and the four FSM States MCH Programs. Once the system is put to use, it will alleviate or eradicate, if you will, all the problems that were cited in the Needs Assessment report and provide answers to all questions and concerns that were raised in the findings of the Needs Assessment relating to developmental screening and admission to the Children with Special Health Care Needs Program. Currently, the tracking system that FSM uses is questionable as it does not have accurate numerator and denominator (as revealed during the 2015 FSM Wide Needs Assessment exercise) to provide accurate count to determine how many CSHCN are being seen and/or receive appropriate and timely health care case management services. The Program tracks percent of children identified with developmental delays that are part of the CSHCN Program. However the numerator is total number of children identified with developmental problems and admitted to the CSHCN Program and the denominator is the total number of children within the CSHCN Program. Therefore the measure of tracking the population is really only a measure of the percent of newly diagnosed CSHCN Program participants for that year. The Program has no specific data on the number or percent of children screened for developmental delays; the number or percent of children found to have neither developmental delays; nor the number or percent of children with

developmental delays receiving services. Nonetheless, based on the tracking system (MCH Data Matrix) that the FSM MCH Program uses to collect and report data on CSHCN, in 2014, 5.5% of CSHCN identified with developmental problems were admitted into the CSHCN Program compared to 9.4% CSHCN admitted in 2013. The slight decrease, as reported by the State MCH Programs, may be related to the decrease in the number of visits to homebound clients and that some specialty services were not held last year, such as the cancelled visit to FSM by the Audiologist. The FSM MCH and FSM Special Education Programs have made an internal arrangement to avoid the gap care reported in the Needs Assessment. Based on the arrangement, the programs will jointly provide education, counseling and required support for the children and their families in the interim and before the arrival of the specialist. This arrangement was made to reduce concern and anxiety of parents whose children are diagnosed with a condition and awaiting a Specialist for confirmation. Transitional services for CSHCN are tracked through the CSHCN Survey. In 2014, 20.3% of youths with special health care needs were reported to have received services necessary to make transition to all aspect of adult life compared to 17.1 % youths with CSHCN reported in 2013. Some of the causes of the slight increase, as reported by the State MCH Programs, included fewer people migrated during the year, lower school enrollment, and improved data reporting. The Children with Special Health Care Needs 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 transitional services.

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

The FSM MCH Program plans to provide more fluoride varnish next year so the reach of the program can grow and reach most of the school across the four states in the FSM. The MCH program also plans to collaborate with the dental division and other health programs doing outreach services to share costs of gasoline and share vehicles to alleviate the transportation problem currently facing the school and community oral health outreach team. The FSM MCH Program plans, as a priority activity, to improve the data collection and reporting efforts to better understand the current situation as well as monitor change over time and evaluate activities meant to improve MCH population health. The FSM National MCH Program also plans to develop common educational messages for the communities to be shared by the State Programs as well as strengthening its National oversight by making more visits to the states next year.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	47.0	50.0	53.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	47.0	50.0	53.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	0.7	0.5	0.3	0.1	0.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	0.7	0.5	0.3	0.1	0.0

In the FSM, dental caries remain one of the most unmet health needs among young children. For most of the children in Head Start, their first dental visit is through the Fluoride Varnish Program. The reach of Fluoride Varnish Program needs to grow in all states in the FSM. In 2014, 28.3% of 1-5 year olds reported to have treated with fluoride varnish, an increase from 24.7% of 1-5 year olds reported in 2013. Although the data reported a slight increase, most states reported that the percent of 1-5 year olds receiving fluoride varnish remain low because fewer schools were visited during the years due to shortage of staff, limited supplies and transportation problem; often no gasoline or vehicle available. The Public Health Dental Clinics serve the entire FSM community. Public health nurses and support staff were trained to do oral health assessment, fluoride varnish application, education/counseling and referral to promote the integration of oral health into clinical services. With funding support from the HRSA Oral Health Workforce Development Grant a three (3) months training program of Dental Assistants, from all the four states in the FSM, are ongoing in Pohnpei. It is hoped that those trained would be mobilized to ease the burden of shortage of dental staff and improve dental service throughout the schools and communities in the FSM States. For pregnant women, a dental check is completed free of charge during prenatal care at the main public health clinic. Dental services are not available at the dispensaries though. There are four private dental clinics in the FSM, three (3) in Pohnpei and one (1) in Chuuk. However, access is somewhat prohibited given that in Chuuk the private clinic is only open for a week every month. The Public Health Dental Clinics, through a Memorandum of Agreement (MOA) with the Department of Education, Early Childhood Education Program, has the only established school prevention programs in the FSM. Dental Assistants, paid by the MCH Program, along with dental nurses from the State Dental division are providing Fluoride Varnish and Dental Sealant in the schools and communities in all states in the FSM. Pohnpei State reported that they visited 8 schools throughout the island this year and provided fluoride varnish to students. Impeding priorities in families' life creates challenges and barriers in seeking preventative health screenings including for oral health. Poor oral health literacy contributes to not seeking preventive oral health services as individuals may not understand the connection of good oral health in relation to their general health. The limited oral health workforce also contributes to not accessing preventive care. The heightened oral health issues found in the FSM is due, in large part, to a high incidence of chewing betel nut, especially in Yap State. Betel (areca) nut chewing is often used in combination with tobacco and slaked lime (predominantly calcium hydroxide). Use of betel nut in adults is very high in the FSM, as well as most of Micronesia, and starts at a young age. The age initiation of chewing betel nut is not uncommon to be as young as 12 years. Betel nut is sold in gas stations, grocery stores, and roadside stands and can be obtained from homegrown trees. It is easily available throughout the FSM and there is no minimum age for purchase. It is estimated that up to 85% of the population of Yap State chew betel nut with tobacco. Because addictive, betel nut users don't stop chewing during pregnancy. Therefore a related finding is the high use of tobacco in pregnancy. As part of the last grant cycle data collection, FSM tracked women who reported smoking in their last three months of pregnancy. The findings of 1.8 % in 2013 and 0.8% in 2014 respectively are quite low, but this does not assess tobacco use outside of smoking. MCH Program intended to track and reduce not just smoking in pregnancy, but all tobacco use in pregnancy. The FSM MCH Program needs to improved data collection. The reliability and validity of the data collected by the States and reported to the National MCH Program is questionable. The data reported from year to year is quite variable without any valid justification for the severe fluctuations. The FSM National MCH Program needs to develop guidance through policies, develop common educational messages for the communities to be shared by State Programs, and strengthen its oversight role to avoid a disjointed program. These initiatives can help produce the unity, organization and consistency that need strengthening while still allowing for some individualization on certain provisions of the program.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

In 2015 there are 36 full-time staff in the four FSM States and at the national program level funded by the MCH and SSDI Program funds. Training and education of the National and State MCH Program Coordinators and Staff are carried out at three levels: (1) Individual on-site consultation has been provided twice a year for the MCH Coordinators and CSHCN Coordinators in the four states on developing policy and procedures, program implementation, data collection, data analysis and interpretation, and improving data capacity. (2) The FSM Annual MCH Workshop that was held in May or June each year and brought 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 Departments where issues were discussed related to improving services and state data capacity and early intervention services for children with special needs, and (3) Special conferences and other educational opportunities were provided to the State MCH Coordinators who attended on-line courses from the Fiji School of Medicine, National and State MCH and CSHCN Coordinators attended the PACRIM Conference in Honolulu, State MCH Physicians attended the Pacific Medical Association Conferences, and MCH nurses attended the American Pacific Nurses Leadership Conference (APNLC) rotating among the Pacific Islands each year. Meanwhile, FSM has completed development of the WebMCH Module, a web-based data collection and reporting system adopted from the WebIZ. The WebIZ is a web-based system developed by Envision Technologies and used by the FSM Immunization Program. The web-MCH Module was completed on February 23, 2015 and deployed onto the production site on June 26, 2015. By December 2015 the System Specialist for the FSM WebIZ will train the FSM National and State MCH Program staff on how to use the system so they can start inputting data into the System beginning in January 2016. The webMCH should imporve data collection, reporting, and or sharing, if you will, at State level and between the States and the National level. Additional in-country trainings are expected onsite in each state and during the FSM MCH Annual Workshops.

II.F.3. Family Consumer Partnership

The MCH Title V Program staff at the state level work closely with parents support groups, church leaders, women's groups, and community and traditional leaders. However, the current use of the parent/consumer partnership is limited in the FSM. Outside the children with special health care needs population, the parent/consumer partnership is non-existent at this time. Within the children with special health care needs population each state has an Inter-Agency Council (IAC) consisting of representative from Public Health, Special Education, community groups such as churches, NGOs and advocacy bodies, as well as parents and consumers of the CSHCN services. Being that each state has an IAC the diversity of each state's population is represented appropriately. As a group focused on CSHCN, they are educated and aware of CSHCN competencies but not MCH core competencies overall. In Kosrae, the IAC meets monthly and has approximately twenty (20) members, half of which are parents and consumers. The members receive a meeting allowance of $20 per meeting. In Chuuk, the IAC has blended with the duplicative Special Education Board which had the same association objectives and focus. The Special Education Board meets quarterly and has approximately fifteen (15) members, half of which are parents or consumers. This board receives no compensation or monetary incentive for participation. In Yap, the IAC is not very active and attempts to meet quarterly but with difficulty. Only one (1) parent serves on the council. In Pohnpei, the IAC has not met for at least two (2) years. Where the IAC is active, parents and consumers have and equal say and equal vote to other members in the business of the council. Council business centers around patient rights, program policies, access issues, and needs and gaps in services provided. The MCH program intends to expand its parent/consumer partnership in the coming years to improve public input into the program and its policies and objectives.

II.F.4. Health Reform

The FSM National Health Department is working closely with the State Health Departments in the four FSM States to build new dispensaries as well as to upgrade the condition and level of existing dispensaries to the minimum standard of a Community Health Center (CHC) Clinic. In the FSM, a Community Health Center has a pharmacy, laboratory, treatment and observation rooms and a full time physician. The FSM health department is encouraging the State Health Departments to add a dental section to the CHCs. Upgrading the standard of the Dispensaries to CHC level would benefit FSM MCH Program's community based approach to implementing MCH Program Services for the next 5 years, especially the program's effort to bring the services to the people such as cervical and anemia screening and dental care. To date all FSM States have secured CHC Program Grant Funds but Chuuk State. In Yap State the CHCs are operating very well. Kosrae recently received CHC Grant Funds and is on final planning stage to construct additional dispensaries. Pohnpei also received additional funding to upgrade two of the existing dispensaries to CHC clinic level. Another reform effort of the FSM is to improve Diagnostic Services in Pohnpei. Currently, an assessment is ongoing to determine what medical equipment to purchase and of what capability is required. Meanwhile, FSM department of Health, MiCARE (FSM Health Insurance Program) and other states' health departments are having conversation with the Medical City Hospital in Guam, an affiliate of the Medical City group in the Philippines, to provide medical consultancy and other needed advanced diagnostic services.

II.F.5. Emerging Issues

An emerging issue of serious concern, not for the Health Department alone but for every institution and people of the Federated States of Micronesia, is the anticipated termination of the Financial Package of the Compact of Free Association at the end of year 2023. At the moment no one really knows what the future holds for the FSM Health Care System but we are optimistic that there will be avenues for conversation on this matter. Currently, the FSM Health Care System is supported and operated on funding provided by US Federal Grant Funds and Compact of Free Association Health Sector Funds. The FSM MCH Program is very concerned also because FSM does not know either, if the US Federal Grant Dollars will terminate when the Compact Sector funds are terminated. FSM Collects several millions of dollars, in local revenues, each year but it is not adequate to cover health, education and social service needs in the four (4) States of the FSM.

II.F.6. Public Input

The Federated States of Micronesia (FSM) Maternal and Child Health (MCH) Program, usually solicited Public Input through (1) the FSM MCH Annual Workshop held each year, and (2) Posting of the MCH Grant Application onto the FSM Public Information Office Website. This year the FSM MCH Program added the FSM State Level 5 Year Needs Assessment exercise to also solicit public input. The Findings of the State Level Needs Assessment were presented and discussed during the FSM MCH Annual Workshop held in Pohnpei State from June 1-5, 2015.

1. FSM MCH State Level 5 Year Needs Assessment: Every five years, the Federated States of Micronesia (FSM), as a Grantee, is required by the Title V legislation to develop a comprehensive statewide needs assessment. 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. FSM's needs assessment process was guided by the MCH Needs Assessment Steering Committee which included the following staff members:
    - Dionis Saimon, Maternal Child Health Program Manager;
    - Stanley Mickey, Family Planning Program Coordinator;
    - Dr. Anamaria Yomai, CSHCN Physician;
    - Pipiana Wichep, Chuuk MCH Services Coordinator;
    - Patricia Tilfas, Kosrae MCH Services Coordinator;

- Marcy Lorrin, Pohnpei MCH Services Coordinator; and
- Denitha Palemar, Yap MCH Services Coordinator.
- The group was assisted by Arielle Buyum, who served as facilitator and process consultant.

Vision & Goal:

To identify 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.

Methodology:

Two part process allowed for individual State input from staff, health and community partners, families, consumers and other key stakeholders into the overall National level needs assessment

Part one: traveled to each State to conduct individual State needs assessments via Priority Health Issues Survey and Strengths, Weaknesses, Opportunities and Threats (S.W.O.T.) analysis on each identified priorityPart two: MCH Annual Meeting in Pohnpei to assess capacity on Structural Resources, Data/Information Systems, Competencies/Skills, and Organizational Relationships and plot grid impact and feasibility to determine final priorities

Data Methods

Utilized:

Title V indicators

Performance measures

Other quantitative and qualitative data

Reviewed by MCH population domain based on data trends:

Major morbidity

Mortality

Health problems

Gaps

Disparities

Cross-cutting needs also examined

Top Priority By Domain for Each State

Perinatal/ Infant	Child	CSHCN	Adolescent	Women's/ Maternal	Cross- Cutting

Kosrae	Increase immunization	Improve access to high quality primary & preventive health care	Access to specialty care and services	Prevent alcohol and drug use	Early and adequate prenatal care	Early coordinated chronic disease prevention
Pohnpei	Reduce infant/fetal death	Increase immunization	Early identification of CSHCN	Promote positive youth development to reduce high risk behaviors	Access to Pap tests	Early coordinated chronic disease prevention
Yap	Reduce infant/fetal death	Access to health care	Access to specialty care and services	Prevent teen pregnancy	Access to Pap tests	Early coordinated chronic disease prevention
Chuuk	Reduce infant/fetal death	Prevent child abuse	Access to specialty care and services	Prevent alcohol and drug use	Early and adequate prenatal care	Early coordinated chronic disease prevention

Top Priority By Domain FSM Overall

Perinatal/ Infant	Child	CSHCN	Adolescent	Women's/ Maternal	Cross- Cutting
Reduce infant/ fetal death	Increase immunization	Access to specialty care and services	Prevent alcohol and drug use	Early and adequate prenatal care	Early coordinated chronic disease prevention

Data Findings

Women/Maternal Health:

Most women in the FSM start Prenatal care late and most are not meeting the required number of prenatal visits. In 2013 only 7.6% of MCH women had a Pap smear. The percent of women who had a Pap smear increased to 16.2% in 2014. It is important to note that in Pohnpei and Yap visual inspection with acetic acid (VIA) is used as an alternative to Pap testing. Even so, the FSM has a very large underserved population who are not receiving recommended annual preventive health services within our community. These women face many barriers to care including:

- Unaware of health needs
- Shame or fear in seeking reproductive health services
- Access to care issues
- Uninsured status
- Transportation issues

- Childcare issues

An assessment of prenatal care conducted at the main hospitals in the FSM showed that almost 70% of deliveries receive inadequate prenatal care. In 2014, about 35% of women observed to have the expected number of visit for prenatal care. In addition, some FSM states report up to 10% of deliveries received no prenatal care at all. MCH Program continues to strive to improve prenatal care adequacy.

Perinatal/Infant Health:

The perinatal mortality rate in the FSM in 2014 was 36 per 1,000 live births compared to 39 per 1,000 live births in 2013. In 2014, the percent of singleton births recorded in the FSM as having low birth weight was at 11%. Lack of screening for gestational diabetes during prenatal care effects newborn outcomes. The MCH Program is committed to improving prenatal care access and adequacy through the MCH clinics and dispensaries in remote villages. Although in 2014, 62.7% of mothers in FSM report breastfeeding their child at six months of age the adequacy of breastfeeding has not been assessed. This measure does not assess exclusive breastfeeding. The qualitative reports from pediatric providers is that although women are still offering the breast at six months, most are supplementing. Anemia is prevalent in the infant population of FSM as well as the childbearing woman population. In 2014, 35.2% of infants up to 1 year old screened were anemic. However, that same year only 16.6% of the infant population was screened. The State MCH Programs will continue to work with other public health programs to improve services for pregnant women in order to improve birth outcomes.

Child Health:

The overall coverage rate of immunization in FSM is quite low at 76% in 2014 and increase from 59% in 2013. Lack of refrigeration of the vaccines makes it difficult to provide vaccination to children of the outer and remote islands. Kosrae, a single island State in the FSM without outer and remote islands the 2014 coverage was 90.7%. In Chuuk, Pohnpei, and Yap outreach and services to the outer islands depends on availability of money for fuel for the ships. FSM children experience many non-fatal injuries. Most of the injuries reported are falls related to play. There are no neighborhood playgrounds offering safe play areas. The MCH Program will share cost of doing outreach so children living in the outer islands can also be vaccinated. The MCH Program staff will work with local and state government officials so a safe playground can be designated and developed to reduce number children who are injured each year.

Adolescent Health:

The FSM teen birth rate for 2014 was 43.6 births per 1,000 females. In Pohnpei, the age of consent is 16 years old. In Yap, the legal age of consent is 13 years old. This past year, Chuuk increased the legal age of consent from 13 to 18 years old. Teen births increase health risks to both mother and child including low birth weight, preterm birth, and death in infancy. 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. High-risk sexual behaviors among adolescents are a significant public health concern in the FSM. These behaviors account for increasing rates of premature morbidity and mortality by contributing to risk of unintended teen pregnancy, HIV/AIDS, and other sexually transmitted diseases. In 2014, 13.8 per 1,000 women aged 15 through 19 years were reported with a case of Chlamydia. During the same year, 96.0 per 100,000 non-fatal injuries due to motor vehicle crashes among children aged 15 through 24 years were reported. There is lack of law enforcement surrounding alcohol sales and many businesses in the FSM sell alcohol cheap and to youth. Teen suicide is an issue in FSM with a rate as high as 61.4/100,000 adolescents being reported in 2014. The FSM MCH Program believes that not all suicides are reported, especially those happening in the outer island, and most suicides reported are alcohol related.

Children with Special Health Care Needs:

FSM MCH Program uses a spreadsheet (MCH Data Matrix) to collect MCH Program data including data for CSHCN Clients and Services. During the review of the State Level Needs Assessment during the FSM MCH Annual Meeting in Pohnpei, we learned that the formula used in calculating screening for development delay and admission into the CSHCN program was inaccurate. FSM MCH Program will rectify the problem as we start reporting on that measure during this application year. Nonetheless, in 2014, the percent of children with identified developmental problems that have been admitted to the CSHCN program (as tracked by FSM MCH CSHCN Program) was reported at 5.5%. During the same year, the percent of CSHCN who received services necessary to make transition to adult life was reported at 20.3%. These problem with lack of data system to report, track or register CSHCNs should be alleviated in the New Year when the WebMCH system is activatedThe Children with Special Health Care Needs Program in FSM relies heavily upon its partnership with the Special Education.

Cross-cutting:

The prevalence of dental caries remains one of the most unmet health needs especially among young children in the FSM. The Public Health Dental Clinics, through a Memorandum of Agreement (MOA) with the Department of Education, Early Childhood Education Program has the only established school prevention programs in the FSM. Although the purpose of the Fluoride Varnish and Sealant programs is to prevent dental caries among children in the FSM, both medical and dental care providers have noted tremendous deficiencies in the oral health status of children here in the FSM. Poor oral health literacy contributes to not seeking preventive oral health services as individuals may not understand the connection of good oral health in relation to their general health. In 2014, 28.3% of children 1-5 years old were reported to have treated with fluoride varnish while 39.8% of third grade children received protective sealants. Dental services for pregnant women are completed free of charge during prenatal care. Chewing betel nut in the FSM, especially in Yap State is the major problem of oral health. Betel (areca) nut chewing is often used in combination with tobacco and slaked lime (predominantly calcium hydroxide). It is estimated that up to 85% of the population of Yap State chew betel nut with tobacco. Because addictive, betel nut users don't stop chewing during pregnancy. As part of the last grant cycle data collection, FSM tracked women who reported smoking in their last three months of pregnancy. The findings of 0.8% in 2014 is quite low, but this does not assess tobacco use outside of smoking. MCH Program intended to track and reduce not just smoking in pregnancy, but all tobacco use in pregnancy.

1. FSM MCH Annual Workshop: The FSM MCH Annual workshop is held each year and the venue rotates among the four (4) FSM States to allow more participants to attend from the host state. This year, the FSM MCH Annual Workshop was held from June 1-5, 2015 in Pohnpei State. The Annual Workshop brought together parent representatives, hospital and public health program administrators, physicians and nurses, police officers, Church leaders, Related Services Assistants (RSAs) from the Early Childhood Education (ECE) and Special Education Programs, including National and State MCH program administrators and staff for the week-long workshop. The annual workshop serves as a venue where the MCH program staff and stakeholders convene for networking or putting our heads together, if you will, to review past year's accomplishments, share success stories for possible adoption and replication by other state programs, identify barriers and discuss challenges and plan program activities for the coming year. This year's annual workshop was more exciting and interactive as the participants reviewed the findings of the FSM MCH State Level Needs Assessments and prepare the 2016 to 2020 MCHB Grant Application. 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. The needs assessment served as a vital planning process for determining where best to focus FSM's MCH efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. FSM also employed a strategic planning process to examine how these new priority areas can be incorporated into the existing MCH scope of work. The outcome of the annual workshop was the development of the 5 year action plan and other information necessary to completing the MCH Block Grant Application for the next program cycle. There was not any major

comment or statements made that stands out of the normal program planning discussions that worth highlighting here.

2. Posting the Application on the FSM Public Information Office (FSM PIO) Website: The FSM MCH Program wanted to garner Public Input from a wide spectrum of interested individuals and parties to provide comments to the 2016 MCH Block Grant Application. Unfortunately, we were unable to complete the Application in time to post it on the FSM Public Information Office Website, therefore this method of soliciting public input for the 2016 grant application was not carried out. Next year, we will try to complete the application far ahead of the deadline so it can be posted on the FSM PIO Website to enable people to review and provide comments.

II.F.7. Technical Assistance

FSM Needs more training in the use of the Title V Information System to better respond to the MCH Block Grant Continuous Application in the subsequent years. FSM also needs more workshops relating to the implementation of the CoIIN Project, improving data collection and reporting of CSHCN issues especially in reporting developmental screening and transitional services and doing survey in oral health.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 539,323	$ 201,238	$ 537,887	$ 269,065
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
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	$ 979,323	$ 641,238	$ 977,887	$ 709,065
Other Federal Funds	$ 272,260	$ 91,045	$ 65,357	$ 65,357
Total	$ 1,251,583	$ 732,283	$ 1,043,244	$ 774,422

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 533,451	$ 509,729	$ 506,219	$
Unobligated Balance	$ 0	$ 61,553	$ 0	$
State Funds	$ 440,000	$ 440,000	$ 440,000	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 973,451	$ 1,011,282	$ 946,219	$
Other Federal Funds	$ 91,045		$ 91,045	$
Total	$ 1,064,496	$ 1,011,282	$ 1,037,264	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 574,649	$
Unobligated Balance	$ 0	$
State Funds	$ 440,000	$
Local Funds	$ 0	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 1,014,649	$
Other Federal Funds	$ 0	$
Total	$ 1,014,649	$

III.A. Expenditures

/2016/ The total expended amount based on the total Notice of Grant Award and actual amount reported on the PMS system as of July 9, 2015. The remaining balance will be spend not later than September 30, 2015. //2016//

III.B. Budget

/2016/ Budget

MCH Budget Narrative

Federated States of Micronesia - FSM

Federated States of Micronesia - FSM

MCH BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2016

PERSONNEL $22,253

A total of $22,252 is requested to continue support the salary of the National MCH Program Manager. The total amount requested includes salary adjustment.

FRINGE BENEFITS $2,448

A total of $2,448 has been set aside for fringe benefits which cover social security,

insurance and other benefits due the staffs. Fringe benefits are based at 11% of the total base salary.

TRAVEL $16,000

A sum $16,000 is requested to fund the national program coordinator and a financial specialist to conduct on site program and financial monitoring in the four (4) FSM states. The

Differences will support the program coordinator and one program staff to attend the MCH

Block Grant Review in Honolulu, HI, and AMCHP meeting in Washington, D.C.

EQUIPMENT $0

No equipment requested in FY-2016.

SUPPLIES AND MATERIALS (EXPENDABLE) $500

This amount is requested to purchase office supplies to maintain the Administrative operation of the MCH Program at the National level.

CONTRACTUAL $1,000

A total of $1,000 is requested to cover the FSM Membership fee to the Association of Maternal and Child Health Program (AMCHP).

OTHER $ 1,500

$500 will cover communication expenses, $500 for POL and $500 for freight.

TOTAL: $43,200

PREGNANT WOMEN, MOTHERS & INFANTS

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2016

PERSONNEL $112,642

The sum of $112,642 has been budgeted to support the salaries of the component staff at

The four (4) States of Kosrae, Chuuk, Pohnpei and Yap.

FRINGE BENEFITS $12,215

Fringe Benefits for the States vary from 7% to 15% of their base salaries. Fringe Benefits cover social security or retirement; medical, dental, and life insurance. Total amount requested for fringe benefits is $12,215 for 2016.

TRAVEL $14,020

This amount will cover intra-island travel to the outer-island to conduct outreach clinic and also attend the APNLC Conference in Yap State.

SUPPLIES $3,000

This amount is to purchase both office, medical, and dental supplies for the four (4) States of Chuuk, Kosrae, Pohnpei and Yap.

EQUIPMENT $4,000

This amount is requested is to purchase sets of computers in FY-2016.

CONTRACTUAL SERVICES $23,500

This amount is requested to contract an off-island Laboratory to read pap smear for the

four (4) FSM States.

OTHER $5,000

This amount requested for FY-2016 is to cover the cost of printing and reproducing MCH educational materials, correspondence, reports; communication (telephone, FAX,); freight and petroleum, oil and lubricant (POL) in the four FSM States.

TOTAL: $174,377

CHILDREN & ADOLESCENTS

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2016

PERSONNEL $112,642

This amount requested will support the salaries of the component staff in each of the four FSM States.

FRINGE BENEFITS $12,214

Fringe Benefits for the States vary from 7% to 15% of their base salaries. Fringe Benefits cover social security or retirement; medical, dental, and life insurance. Total amount requested for fringe benefits is $12,214 for 2016.

TRAVEL $14,020

This amount requested is budgeted for intra-island travels to the outer-islands to conduct outreach clinic.

SUPPLIES $9,000

This amount is to purchase office and medical supplies for the MCH and Dental Program in the four (4) States of Chuuk, Kosrae, Pohnpei and Yap.

EQUIPMENT $8,000

A total amount requested is to purchase set of computers.

CONTRACTUAL SERVICES: $6,240

A total amount requested is to s upport breastfeeding support group.

OTHER $12,100

A total of $12,100 is requested to accommodate the costs of printing and reproduction, communication, freight, fuel, oil and lubricant for Chuuk, Kosrae, Pohnpei and Yap.

TOTAL: $174,216

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2016

PERSONNEL: $67,844

A total amount of $67,844 is requested to continue support the salaries of the National CSHCN Physician and the four (4) CSHCN Coordinators in the four FSM States.

FRINGE BENEFITS: $8,012

Fringe Benefits for the States and National Government vary from 7% to 14% of their base salaries. Fringe Benefits cover social security or retirement; medical, dental, and life insurance. Total amount requested for fringe benefits is $8,012 for 2015.

TRAVEL: $42,000

$42,000 will support off-island travel cost for the following program activities: 1) National MCH Program Manager and CSHCN Physician at the National Level to attend the AMCHP Conference in Washington, D.C.; 2) To continue fund travel of the off-island pediatric cardiologist team from Children Hospital Orange County (CHOC) in California to continue visit the four (4) FSM states. 3) To support travel of the National CSHCN Physician to visit the four States in the FSM.

SUPPLIES: $40,000

$40,000 is requested to purchase medical supplies such as long acting Bicilline, Multi

Vitamin, and Albendazole for the four FSM states.

CONTRACTUAL SERVICES: $10,000

$10,000 is requested to continue contract the Pediatric Cardiologist Team from Children Hospital Orange County (CHOC) in California to provide services in the four FSM states.

OTHER: $15,000

A sum of $15,000 is requested to support the CSHCN program activities in the four FSM

States based on a proposal submission to the FSM National Government.

TOTAL: $182,856

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2016

State of Chuuk

PERSONNEL: $88,765

A total of $88,765 is requested to continue support the salaries of the MCH Coordinators, two (2) graduate nurse, three (3) practical nurses, three (3) Health Assistants, one (1) health educator, one (1) MCH Secretary, one (1) Data clerk, one (1) Dental Assistant and one (1) Health Services Federal Program Coordinator.

FRINGE BENEFITS: $12,427

To cover the social security, insurance and other benefits due the staff, total of $12,427 is budgeted based on 14% of the total base salary.

TRAVEL: $8,540

$5,040 is requested for intra-island travel to the lagoon and outer-islands to conduct outreach clinic and Administration of Survey (PRAMS/SLAIT). The differences will support one program staff to attend the APNLC conference in Yap State.

EQUIPMENT: $3,000

A total of $3,000 is requested to purchase one set of Desktop Computer with accessories.

SUPPLIES: $10,000

a) Medical and Dental Supplies $9,000

A sum of $8,000 is requested to purchase medical supplies including prenatal tablets,

iron tablets and liquid, multi-vitamins and tempra for children. $1,000 is to purchase dental supplies.

b) Office supplies (Expendable) $1,000

A total amount of $1,000 is requested to purchase office supplies to run MCH Clinic in the

Main center and out in the outer islands.

CONTRACTUAL SERVICES: $7,000

A total amount of $7,000 is requested for contractual services. Of this amount, $6,500 will

Continue to contract a Lab-Tech Company in Guam for reading pap smears. $500 will be used to support a Breast Feeding Support Group in the community.

OTHER: $4,000

A total amount of $4,000 is requested for Printing and Reproduction; Communication and Petroleum Oil and Lubricant (POL).

TOTAL: $133,732

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2016

State of Kosrae

PERSONNEL: $23,506

This amount requested is to continue support the salary of four (4) full time staff servicing

MCH Program. This includes the MCH Coordinator, MCH Staff Nurse, and one Dental Assistant.

FRINGE BENEFITS: $3,526

Fringe benefit at the rate of 15% of the base salary is set aside for social security,

insurance and other benefits.

TRAVEL: $3,500

A sum of $3,500 is requested to support the travel of the program coordinator to attend the APNLC Conference in Yap State.

EQUIPMENT: $0

No equipment requested in FY-2016.

SUPPLIES: $1,000

A total of $1,000 is requested to purchase office supplies to support MCH program in the

Center and out in the Fields.

CONTRACTUAL SERVICES: $10,740

a) A sum of $5,000 is requested to continue contract Lab-Tech Company in Guam for pap smears reading.

b) A sum of $5,740 is requested to continue fund four (4) Breast Feeding Support Group

Members that working with mothers to support exclusive breast feeding in the communities and at the central clinics.

OTHER: $8,000

A sum of $5,000 is requested to purchase medical supplies including prenatal tablets,

iron tablets and liquid, multi-vitamins and tempra for children. $2,000 for communication, printing, and reproduction and POL for outreach activities in the communities and $1,000 to support the Breast Feeding Week.

TOTAL: $50,272

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2016

State of Pohnpei

PERSONNEL: $59,168

A total $59,168 is requested to continue supporting the salaries of the Five (5) existing

MCH Staffs. This includes the MCH Coordinator, one (1) MCH Nurse, one (1) MCH dental nurse, one (1) MCH dental assistant and one (1) MCH Account Tech. II.

FRINGE BENEFITS: $4,438

This amount is based on 7.5% of the base salary for social security and other benefits due

the staff.

TRAVEL: $11,840

$8,340 is requested for intra-island travel to do an outreach clinic in the outer-islands. The differences will support one Program Nurse to attend the APNLC conference in Yap state.

SUPPLIES: $10,500

a) Medical Supplies: $8,500; This amount is requested to purchase prenatal vitamins, iron

tablets and liquid, multi-vitamin drops, Tylenol or Tempra liquid for the children.

c) Office Supplies (Expendable): $2,000; To purchase office supplies and materials.

EQUIPMENT: $4,000

A sum of $4,000 is requested to purchase one Lap-top computer and a printer for the program needs.

CONTRACTUAL SERVICES: $6,000

A sum of $6,000 is requested to continue contract Lab-Tech Company in Guam for reading pap smears.

OTHERS: $3,000

A sum of $3,000 is requested for Consumable Goods. a) $500 for communication; b) $2,000

for Petroleum Oil and Lubricant (POL) and c) $500 for repair and maintenance of the program vehicle.

Total: $98,946

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2016

State of Yap

PERSONNEL: $53,845

$53,845 is requested to continue support salaries of eight (8) existing MCH staffs. One (1) MCH Coordinator, two (2) MCH nurse, three (3) MCH dental nurse, one (1) nutritionist and one

(1) Federal Accounts Clerk.

FRINGE BENEFITS: $4,038

Fringe benefit is based on 7.5% of the total base salary, which covers social security,

Insurance and other benefits due the staff.

TRAVEL: $4,160

A sum of $4,160 is requested for intra-island travel to conduct outreach clinics.

EQUIPMENT: $5,000

A sum of $5,000 is requested to purchase standing-baby scales for well-baby clinics and breast pump for working mothers.

SUPPLIES: $8,500

Medical and Dental Supplies:

The amount of $5,000 is requested to purchase medical supplies including prenatal tablets,

iron tablets and liquid, multi-vitamins and tempra for children, sealants and fluoride &

silver fluoride varnish for infants and children. The differences amount of $500 will be use

to purchase office supplies.

CONTRACTUAL SERVICES: $6,000

A sum of $6,000 is requested to continue contract Lab-Tech Company in Guam for pap smears reading.

OTHER: $2,100

A sum of $1,600 is requested to support Yap Interagency Nutrition Education Council in

It’s efforts to promote "Go Local" in communities and $500 is to purchase Petroleum, Oil and Lubricant (POL).

TOTAL: $83,643

//2016//

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

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

Supporting Document #01 - CV's.pdf

Supporting Document #02 - FSM - Org. Chart.pdf

Supporting Document #03 - Cover Letter.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Federated States of Micronesia

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 574,649	$ 509,729
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 174,216 (30.3%)	$ 153,800 (30.2%)
B. Children with Special Health Care Needs	$ 182,856 (31.8%)	$ 162,168 (31.8%)
C. Title V Administrative Costs	$ 43,200 (7.5%)	$ 43,899 (8.6%)
2. UNOBLIGATED BALANCE	$ 0	$ 61,553
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 440,000	$ 440,000
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 0	$ 0
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 440,000	$ 440,000
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 440,000	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 1,014,649	$ 1,011,282
(Same as item 18g of SF-424)		
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	$ 0	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 1,014,649	$ 1,011,282
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 533,451
A. Preventive and Primary Care for Children	$ 163,736
B. Children with Special Health Care Needs	$ 176,865
C. Title V Administrative Costs	$ 53,112
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 440,000
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 440,000

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9. OTHER FEDERAL FUNDS

No Other Federal Programs were provided by the State on Form 2 Line 9.

Form Notes For Form 2:

/2016/ The total FSM Budget Requested in FY-14 is $533,451. The total Notice of Grant Award receipt for this fiscal year was $509, 729. The total expenditures during this reporting period was $448,176, $56,979 was the remaining balance and $4,574 is unliquidated during this reporting period. //2016//

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ this is the total expenditures reported during this reporting period.//2016//	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ Total expenditures based on the total approve award in FY-2014.//2016//	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2015/ This is the total expenditures reported during this reporting period. //2015//	
4.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ during this reporting period, a total of $56,979 is the remaining balance and a total amount of $4,574 is Unliquidated. //2016//	
5.	**Field Name:**	**8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ $888,176 is the total expenditures during this reporting period.//2016//	

6.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
/2016/ The total Grant Award receipt is $509,729.00. The total expenditures during this reporting period is $448,176. //2016//

Data Alerts: None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Federated States of Micronesia

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 70,302	$ 64,901
2. Infants < 1 year	$ 100,198	$ 103,905
3. Children 1-22 years	$ 136,895	$ 103,904
4. CSHCN	$ 182,856	$ 157,561
5. All Others	$ 43,200	$ 17,905
Federal Total of Individuals Served	$ 533,451	$ 448,176
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 66,000	$ 112,000
2. Infants < 1 year	$ 52,800	$ 85,600
3. Children 1-22 years	$ 61,600	$ 110,000
4. CSHCN	$ 132,000	$ 132,000
5. All Others	$ 127,600	$ 400
Non Federal Total of Individuals Served	$ 440,000	$ 440,000
Federal State MCH Block Grant Partnership Total	$ 973,451	$ 888,176

Form Notes For Form 3a:

/2016/ The total Award in FY-2014 is $509,729. The total expenditures reported during this reporting period was $448,176, the amount of $56,979 is the remaining balance during this reporting period and $4,574 is the unliquidated amount //2016//

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: /2016/ This is the only amount that was spend during this reporting period. //2016//	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ This total expenditures based on the total award receipt in FY-2014.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ This total expenditures based on the total award receipt in FY-2014.//2016//	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ this is the total expenditures during this reporting period based on the approve budget for FY-2014. //2016//	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/ This is total expenditures is based on the approve award for FY-2014. //2016//	
6.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**

	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/Total expenditures during this reporting period based on the approve award in FY-2014. //2016//	
7.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: /2016/This is the total expenditures reported during this reporting period.//2016//	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Federated States of Micronesia

	FY16 Application Budgeted	FY14 Annual Report Expended
II. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 531,449	$ 509,729
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 174,377	$ 161,750
B. Preventive and Primary Care Services for Children	$ 174,216	$ 170,696
C. Services for CSHCN	$ 182,856	$ 177,283
2. Enabling Services	$ 11,600	$ 0
3. Public Health Services and Systems	$ 31,600	$ 0
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		$ 88,809
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 92,091
Dental Care (Does Not Include Orthodontic Services)		$ 108,097
Durable Medical Equipment and Supplies		$ 111,964
Laboratory Services		$ 108,768
Direct Services Total		$ 509,729
Federal Total	$ 574,649	$ 509,729

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 356,000	$ 440,000
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 110,000	$ 125,649
B. Preventive and Primary Care Services for Children	$ 114,000	$ 132,573
C. Services for CSHCN	$ 132,000	$ 181,778
2. Enabling Services	$ 24,000	$ 0
3. Public Health Services and Systems	$ 60,000	$ 0
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		$ 98,000
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 25,000
Dental Care (Does Not Include Orthodontic Services)		$ 86,975
Durable Medical Equipment and Supplies		$ 195,025
Laboratory Services		$ 35,000
Direct Services Total		$ 440,000
Non-Federal Total	$ 440,000	$ 440,000

Form Notes For Form 3b:

/2016/ A total expenditures during this reporting period is $448,175. //2016//

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
/2016/ As of July 9, 2015, this is the only expenditures FSM can reported in this report. The remaining balance will be spend not later than September 30, 2015. //2016//

Form 4

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

State: Federated States of Micronesia

Total Births by Occurrence 1,991

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	1 (0.1%)	0	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	1 (0.1%)	0	0	0 (0%)
Methylmalonic acidemia (cobalamin disorders)	1 (0.1%)	0	0	0 (0%)
Isovaleric acidemia	1 (0.1%)	0	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	1 (0.1%)	0	0	0 (0%)
3-Hydroxy-3-methyglutaric aciduria	1 (0.1%)	0	0	0 (0%)
Holocarboxylase synthase deficiency	1 (0.1%)	0	0	0 (0%)
ß-Ketothiolase deficiency	1 (0.1%)	0	0	0 (0%)
Glutaric acidemia type I	1 (0.1%)	0	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	1 (0.1%)	0	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	1 (0.1%)	0	0	0 (0%)
Very long-chain acyl-CoA dehydrogenase deficiency	1 (0.1%)	0	0	0 (0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	1 (0.1%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Trifunctional protein deficiency	1 (0.1%)	0	0	0 (0%)
Argininosuccinic aciduria	1 (0.1%)	0	0	0 (0%)
Citrullinemia, type I	1 (0.1%)	0	0	0 (0%)
Maple syrup urine disease	1 (0.1%)	0	0	0 (0%)
Homocystinuria	1 (0.1%)	0	0	0 (0%)
Classic phenylketonuria	1 (0.1%)	0	0	0 (0%)
Tyrosinemia, type I	1 (0.1%)	0	0	0 (0%)
Primary congenital hypothyroidism	1 (0.1%)	0	0	0 (0%)
Congenital adrenal hyperplasia	1 (0.1%)	0	0	0 (0%)
S,S disease (Sickle cell anemia)	1 (0.1%)	0	0	0 (0%)
S, βeta-thalassemia	1 (0.1%)	0	0	0 (0%)
S,C disease	1 (0.1%)	0	0	0 (0%)
Biotinidase deficiency	1 (0.1%)	0	0	0 (0%)
Critical congenital heart disease	1 (0.1%)	0	0	0 (0%)
Cystic fibrosis	1 (0.1%)	0	0	0 (0%)
Hearing loss	1,957 (98.3%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Severe combined immunodeficiences	1 (0.1%)	0	0	0 (0%)
Classic galactosemia	1 (0.1%)	0	0	0 (0%)

1b. Secondary RUSP Conditions

None

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	1,957 (98.3%)	6	3	3 (100.0%)

3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Pap Smear Screening	887	27	0	0

4. Long-Term Follow-Up

FSM has an interagency team comprising of MCH/CSHCN program staff, Special Education Related Services Assistants (RSAs) and parent representatives who screen, diagnosed, and follow through (after confirmation of cases) cases with the schools, if the children are in the school and with parents at home, if the children are homebound.

Form Notes For Form 4:

FSM does not have the capability to carry out the following Screening Services. Numbers are dummy therefore ignore it. Not applicable to FSM.

Field Level Notes for Form 4:

None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Federated States of Micronesia

Reporting Year 2014

		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	2,289	0.0	0.0	100.0	0.0	0.0
2. Infants < 1 Year of Age	2,016	0.0	0.0	100.0	0.0	0.0
3. Children 1 to 22 Years of Age	17,398	0.0	0.0	100.0	0.0	0.0
4. Children with Special Health Care Needs	1,687	0.0	0.0	100.0	0.0	0.0
5. Others	17,511	0.0	0.0	100.0	0.0	0.0
Total	40,901					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b

Total Recipient Count of Individuals Served by Title V

State: Federated States of Micronesia

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	2,266
2. Infants < 1 Year of Age	1,957
3. Children 1 to 22 Years of Age	1
4. Children with Special Health Care Needs	1,687
5. Others	200
Total	6,111

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6

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

State: Federated States of Micronesia

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	1,957	0	0	0	0	1,957	0	0
Title V Served	1,957	0	0	0	0	1,957	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0
2. Total Infants in State	3,896	0	0	0	0	3,896	0	0
Title V Served	1,957	0	0	0	0	1,957	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	1,957	0	0	1,957
Title V Served	1,957	0	0	1,957
Eligible for Title XIX	0	0	0	0
2. Total Infants in State	3,896	0	0	3,896
Title V Served	1,957	0	0	1,957
Eligible for Title XIX	0	0	0	0

Form Notes For Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Title XIX is not applicable to FSM.	
2.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Title XIX is not applicable to FSM.	

Form 7

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

State: Federated States of Micronesia

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(691) 320-2619 x103	(691) 320-2619 x103
2. State MCH Toll-Free "Hotline" Name	FSM Dept. of Health and Social Affairs (MCH Progra	FSM Dept. of Health and Social Affairs-MCH Program
3. Name of Contact Person for State MCH "Hotline"	Mr. Dionisio E. Saimon	Mr. Dionisio E. Saimon
4. Contact Person's Telephone Number	(691) 320-2619 x103	(691) 320-2619 x103
5. Number of Calls Received on the State MCH "Hotline"		4
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	Not Applicable	N/A
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	webmail.fsmhealth.fm	webmail.fsmhealth.fm
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites	Not Applicable	N/A
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes For Form 7:

FSM Telecommunications Corporation does not have Toll Free "Hotline" Numbers

Form 8
State MCH and CSHCN Directors Contact Information

State: Federated States of Micronesia

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Mr. Dionis E. Saimon
Title	Program Manager
Address 1	P.O. Box PS 70
Address 2	
City / State / Zip Code	Pohnpei / FM / 96941
Telephone	(691) 320-2619 x103
Email	desaimon@fsmhealth.fm

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Mr. Dionis E. Saimon
Title	Program Manager
Address 1	P.O. Box PS 70
Address 2	
City / State / Zip Code	Pohnpei / FM / 96941
Telephone	(691) 320-2619 x103
Email	desaimon@fsmhealth.fm

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Federated States of Micronesia

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improve women's health through cervical cancer and anemia screening	New	Increase women receiving a well woman visit including Pap or VIA
2.	Improve perinatal/infant outcomes through Gestational Diabetes and anemia screening during early and adequate prenatal care, hearing and anemia screening of the infant and promoting breastfeeding.	Continued	Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9
3.	Improve child health through providing vaccinations and screening for developmental delays	Replaced	Increase children receiving developmental screening
4.	Reduce childhood injury	New	Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9
5.	Improve adolescent health by providing well medical visits and promoting healthy adolescent behaviors and reducing risk behavior (i.e. drug and alcohol use) and poor outcomes (i.e. teen pregnancy, inj	Continued	Increase adolescents receiving a well visit
6.	Provide a transitional services for youth identified as having Special Health Care Needs	New	Increase CSHCN receiving transitional services
7.	Improve identification of CSHCN through screening for developmental delays	New	Increase children receiving developmental screening
8.	Improve oral health of children	Continued	Increase children receiving a preventative dental visit
9.	Reduce tobacco use in pregnant women	New	Decrease percent of women who use tobacco during pregnancy

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Federated States of Micronesia

Form Notes for Form 10a NPMs and NOMs:

The data is an estimates based on data provided for the age group 15 to 24.

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	21.8
Numerator	426
Denominator	1,957
Data Source	Birth Certificate
Data Source Year	2014

NOM-1 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM-2 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #2. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	264.8
Numerator	6
Denominator	2,266
Data Source	Perinatal Clinic
Data Source Year	2014

NOM-3 Notes:

None

Data Alerts: None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	6.3
Numerator	124
Denominator	1,957
Data Source	Vital Statistics
Data Source Year	2014

NOM-4.1 Notes:

None

Data Alerts: None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	0.3
Numerator	5
Denominator	1,957
Data Source	Birth Certificates
Data Source Year	2014

NOM-4.2 Notes:

None

Data Alerts: None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

FAD Not Available for this measure.

NOM-4.3 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #4.3. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-5.1 Percent of preterm births (<37 weeks)

FAD Not Available for this measure.

NOM-5.1 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #5.1. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-5.2 Percent of early preterm births (<34 weeks)

FAD Not Available for this measure.

NOM-5.2 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #5.2. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-5.3 Percent of late preterm births (34-36 weeks)

FAD Not Available for this measure.

NOM-5.3 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #5.3. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-6 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #6. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-7 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	36.2
Numerator	73
Denominator	2,015
Data Source	Vital Statistics
Data Source Year	2014

NOM-8 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	21.5
Numerator	42
Denominator	1,957
Data Source	Vital Statistics
Data Source Year	2014

NOM-9.1 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	15.3
Numerator	30
Denominator	1,957
Data Source	Vital Statistics
Data Source Year	2014

NOM-9.2 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	6.1
Numerator	12
Denominator	1,957
Data Source	Vital Statistics
Data Source Year	2014

NOM-9.3 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM-9.4 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #9.4. This outcome measure is linked to the selected NPM 1,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-9.5 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #9.5. This outcome measure is linked to the selected NPM 4,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts: None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

FAD Not Available for this measure.

NOM-11 Notes:

None

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)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

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 12 months

FAD Not Available for this measure.

NOM-14 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #14. This outcome measure is linked to the selected NPM 13,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-15 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #15. This outcome measure is linked to the selected NPM 7,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-16.1 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #16.1. This outcome measure is linked to the selected NPM 7,10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-16.2 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #16.2. This outcome measure is linked to the selected NPM 7,10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	61.4
Numerator	7
Denominator	11,392
Data Source	Vital Statistics
Data Source Year	2014

NOM-16.3 Notes:

None

Data Alerts: None

NOM-17.1 Percent of children with special health care needs

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	4.3
Numerator	1,687
Denominator	39,590
Data Source	CSHCN Registry
Data Source Year	2014

NOM-17.1 Notes:

None

Data Alerts: None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	85.2
Numerator	1,438
Denominator	1,687
Data Source	CSHCN Registry
Data Source Year	2014

NOM-17.2 Notes:

None

Data Alerts: None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

FAD Not Available for this measure.

NOM-17.3 Notes:

None

Data Alerts: None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

FAD Not Available for this measure.

NOM-17.4 Notes:

None

Data Alerts: None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

FAD Not Available for this measure.

NOM-18 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #18. This outcome measure is linked to the selected NPM 10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-19 Percent of children in excellent or very good health

FAD Not Available for this measure.

NOM-19 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #19. This outcome measure is linked to the selected NPM 6,10,12,13,14,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	7.7
Numerator	261
Denominator	3,373
Data Source	Well Baby Clinic
Data Source Year	2014

NOM-20 Notes:

None

Data Alerts: None

NOM-21 Percent of children without health insurance

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	67.7
Numerator	26,794
Denominator	39,590
Data Source	Census Data
Data Source Year	2014

NOM-21 Notes:

None

Data Alerts: None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

FAD Not Available for this measure.

State Provided Data	
	2014
Annual Indicator	75.5
Numerator	4,032
Denominator	5,339
Data Source	Immunization Data
Data Source Year	2014

NOM-22.1 Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM-22.2 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #22.2. This outcome measure is linked to the selected NPM 10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-22.3 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #22.3. This outcome measure is linked to the selected NPM 10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-22.4 Notes:

None

Data Alerts:

1.	Data has not been entered for NOM #22.4. This outcome measure is linked to the selected NPM 10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

FAD Not Available for this measure.

NOM-22.5 Notes:

None

Data Alerts:

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

Form 10a
National Performance Measures (NPMs)

State: Federated States of Micronesia

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.0	30.0	40.0	50.0	60.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	73.0	75.0	80.0	85.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	73.0	75.0	80.0	85.0

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	10.0	12.0	15.0	17.0	20.0

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	320.0	310.0	300.0	280.0	270.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	48.0	50.0	52.0	55.0	58.0

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.0	27.0	30.0	33.0	35.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	47.0	50.0	53.0

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	43.0	45.0	47.0	50.0	53.0

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	0.7	0.5	0.3	0.1	0.0

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	0.7	0.5	0.3	0.1	0.0

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Federated States of Micronesia

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Federated States of Micronesia

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d

National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Federated States of Micronesia

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	80.0	0.0	1.0	1.0	1.0
Annual Indicator	0.0	0.0	100.0	100.0	
Numerator	0	0	1	1	
Denominator	1	1	1	1	
Data Source	Newborn Screening Program	Newborn Screening Program	Newborn Screening	Newborn Screening	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: FSM lacks the capacity to do blood-spot screening. The number is a dummy so please ignore it. Not applicable to FSM.	
2.	**Field Name:**	**2013**
	Field Note: /2015/ Currently, FSM is not doing blood spot screening. FSM will commence blood spot screenig when funds are made available. //2015.	
3.	**Field Name:**	**2012**
	Field Note: //2014// National Performance Measure #1 is Not Applicable to FSM. The number is a dummy so please ignore it. //2014//	
4.	**Field Name:**	**2011**

Field Note:
//2013// National Performance Measure #1 is Not Applicable to FSM. The number is a dummy so please ignore it. //2013//

Data Alerts: None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	80.0	55.0	75.0	60.0	63.0
Annual Indicator	53.7	70.5	59.9	77.5	
Numerator	647	864	984	1,308	
Denominator	1,204	1,226	1,644	1,687	
Data Source	IEP/CSHCN Program	IEP/CSHCN Program	IEP/CSHCN Program	IEP/CSHCN Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	85.0	58.0	75.0	78.0	80.0
Annual Indicator	55.3	70.2	77.9	77.5	
Numerator	666	861	1,280	1,308	
Denominator	1,204	1,226	1,644	1,687	
Data Source	Public Health Record	Public Health Record	Public Health Record	Public Health Record	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	70.0	15.0	12.0	13.0	14.0
Annual Indicator	13.2	11.0	12.6	12.4	
Numerator	159	132	207	210	
Denominator	1,204	1,198	1,644	1,687	
Data Source	Public Health Record	Public Health Record	Public Health Record	Public Health Record	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	80.0	50.0	47.0	55.0	60.0
Annual Indicator	46.3	45.7	52.3	85.2	
Numerator	535	547	859	1,438	
Denominator	1,156	1,198	1,644	1,687	
Data Source	Public Health Record	Public Health Record	Public Health Record	Public Health Record	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	70.0	26.0	11.0	17.5	18.0
Annual Indicator	25.2	10.4	17.1	20.3	
Numerator	304	124	281	342	
Denominator	1,204	1,198	1,644	1,687	
Data Source	Public High School	Public High School	Public High School	Public High School	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	70.0	50.0	51.0	65.0	70.0
Annual Indicator	48.2	50.5	59.2	75.5	
Numerator	1,694	2,004	2,592	4,032	
Denominator	3,516	3,966	4,379	5,339	
Data Source	Immunization Record	Immunization Record	Immunization Record	Immunization Record	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	30.0	12.0	15.0	22.0	20.0
Annual Indicator	12.3	16.2	22.4	43.6	
Numerator	92	71	157	169	
Denominator	7,482	4,390	7,012	3,876	
Data Source	Birth Certificate/Census Data	Birth Certificate/Census Data	Birth Certificate	Birth Certificate	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	75.0	50.0	34.0	41.0	41.5
Annual Indicator	47.3	32.4	40.1	39.8	
Numerator	1,805	987	1,297	988	
Denominator	3,815	3,051	3,234	2,480	
Data Source	Dental Program/Dept. of Education	Dental Program/Dept. of Education	Dental Program	Dental Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	3.0	2.6	0.0	0.0	0.0
Annual Indicator	2.6	0.0	0.0	0.0	
Numerator	1	0	0	0	
Denominator	38,253	37,861	37,521	37,251	
Data Source	Vital Statistics/Census data	Vital Statistics/Census data	Vital Statistics/Census data	Vital Statistics/Census data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: /2015/ No deaths among this age group reported. //2015//	
2.	**Field Name:**	**2012**
	Field Note: Not applicable to FSM.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 10. Please review your data to ensure this is correct.

2.	A value of zero has been entered for the numerator for year 2014 NPM# 10. Please review your data to ensure this is correct.

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	75.0	70.0	72.0	80.0	82.0
Annual Indicator	65.8	70.4	78.7	62.7	
Numerator	981	1,068	1,350	1,228	
Denominator	1,492	1,518	1,715	1,957	
Data Source	MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	90.0	92.0	90.0	95.0	96.0
Annual Indicator	90.6	86.7	92.0	77.5	
Numerator	1,801	1,855	1,718	1,370	
Denominator	1,987	2,140	1,868	1,767	
Data Source	Hearing Screening Program/Birth Certificates	Hearing Screening Program/Birth Certificates	Hearing Screening Program/Birth Certificate	Hearing Screening Program/Birth Certificate	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	30.0	50.0	27.0	93.0	91.0
Annual Indicator	52.8	28.1	93.8	66.8	
Numerator	23,198	10,652	42,631	27,313	
Denominator	43,937	37,890	45,447	40,882	
Data Source	MCH Data/Census Data	MCH Data/Census Data	MCH Data/Census Data	MCH Data/Census Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	7.0	7.0	23.0	12.0	11.5
Annual Indicator	7.4	24.8	12.1	12.9	
Numerator	93	477	199	214	
Denominator	1,250	1,926	1,649	1,661	
Data Source	ECE Program	ECE Program	ECE Program	ECE Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	1.5	2.0	1.4	1.0	1.0
Annual Indicator	2.1	1.5	1.8	0.8	
Numerator	46	35	35	18	
Denominator	2,240	2,385	1,907	2,289	
Data Source	MCH/ANC Registry	MCH/ANC Registry	MCH/ANC Registry	MCH/ANC Registry	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	2.0	8.0	33.0	8.0	7.5
Annual Indicator	8.6	34.7	8.7	61.4	
Numerator	1	4	1	7	
Denominator	11,621	11,527	11,433	11,392	
Data Source	Vital Statistics/Census	Vital Statistics/Census	Vital Statistics/Census	Vital Statistics/Census	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

None

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	1.0	1.0
Annual Indicator	0.0	0.0	0.0	100.0	
Numerator	0	0	0	1	
Denominator	1	1	1	1	
Data Source	Hospital Discharge Record/Birth Certificate	Hospital Discharge Record/Birth Certificate	Hospital Discharge Record/Birth	Hospital Discharge Record/Birth	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: FSM does not have facilities for high risk deliveries. Numbers are only dummies so please ignore it. Not applicable to FSM.	
2.	**Field Name:**	**2013**
	Field Note: /2015/ National Performance #17 is not Applicable to FSM. FSM does not have such facilities. //2015	
3.	**Field Name:**	**2012**
	Field Note: /2014/ Not Applicable to FSM. The number is a dummy so please ignore it. //2014//	
4.	**Field Name:**	**2011**
	Field Note: /2013/ Not Applicable to FSM. The number is a dummy so please ignore it. //2013//	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 NPM# 17. Please review your data to ensure this is correct.

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	50.0	20.0	20.0	24.0	24.5
Annual Indicator	19.9	19.2	23.6	21.8	
Numerator	459	411	440	426	
Denominator	2,306	2,140	1,868	1,957	
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2013**

Field Note:
/2015/ FSM is looking into the possiblity to adopting the WHO Index of Antenatal care which requires only two visits if the pregnancy is health. A FSM wide training has been done and each state will do their own training. Once the state staff are ready and the WHO Model is approved by the State Directors, the model will be utilized. This will improve NPM # 18. //2015//

2. **Field Name:** **2012**

Field Note:
/2014/The cause of the decrease, as reported by the Chuuk MCH Program, was due to the fact that services were not easily accessible, cost of transportation, clinci waiting time cultural barriers that makes some women avoid any examinations or screening done to their most privat areas (pap smears, pelvic exam, HIV/AIDS and STDs).

Data Alerts: None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Federated States of Micronesia

SPM 1 - The percent of women receiving services in the MCH Programs who receive a Pap smear.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	25.0	25.0	30.0
Annual Indicator	23.7	22.3	24.9	16.2	
Numerator	779	735	788	887	
Denominator	3,288	3,300	3,161	5,461	
Data Source	MCH Program Data	MCH Program Data	MCH Program Data	MCH Program Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 2 - Percent of children with identified developmental problems who are admitted to the CSHCN Program.

	2011	2012	2013	2014	2015
Annual Objective	30.0	30.0	3.0	3.0	2.5
Annual Indicator	3.2	6.4	9.4	5.5	
Numerator	39	47	155	99	
Denominator	1,230	735	1,644	1,792	
Data Source	CSHCN Registry	CSHCN Registry	CSHCN Registry	CSHCN Registry	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 3 - Percent pregnant women attending prenatal care who are screened for low hemoglobin.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	95.0	98.0	99.0
Annual Indicator	92.6	62.3	97.8	99.3	
Numerator	2,172	1,716	1,959	2,124	
Denominator	2,345	2,755	2,004	2,139	
Data Source	Prenatal Clinic/Lab	Prenatal Clinic/Lab	Prental Clinic/Lab	Prental Clinic/Lab	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 4 - Percent chilren 1-5 years old who treated for flouride varnish.

	2011	2012	2013	2014	2015
Annual Objective	30.0	30.0	35.0	28.0	30.0
Annual Indicator	21.4	30.1	24.7	28.3	
Numerator	3,251	4,022	3,545	2,823	
Denominator	15,190	13,365	14,367	9,984	
Data Source	Well Baby Clinic/ECE Records	Well Baby Clinic/ECE Records	Well Baby Clinic/ECE Records	Well Baby Clinic/ECE Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 5 - Percent of children with special needs who have a completed reevaluation by the CSN team within the last 12 months.

	2011	2012	2013	2014	2015
Annual Objective	40.0	40.0	40.0	50.0	50.5
Annual Indicator	38.0	26.2	45.7	31.0	
Numerator	457	518	751	555	
Denominator	1,204	1,979	1,644	1,792	
Data Source	CSHCN Program	CSHCN Program	CSHCN Program	CSHCN Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 6 - Percent of women of child-bearing age who attended workshops in the schools and communities during the reporting period.

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	50.0	60.0	60.5
Annual Indicator	40.6	40.0	58.7	51.0	
Numerator	16,164	17,710	25,904	12,363	
Denominator	39,783	44,275	44,154	24,245	
Data Source	Public Health Records	Public Health Records	Public Health Records	Public Health Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 7 - The rate of maternal deaths in the reporting year.

	2011	2012	2013	2014	2015
Annual Objective	0.0	0.0	0.0	0.0	0.0
Annual Indicator	1.7	1.7	0.0	2.6	
Numerator	4	4	0	6	
Denominator	2,360	2,424	2,316	2,266	
Data Source	Prenatal Clinic Data	Prenatal Clinic Data	Prenatal Clinic Data	Prenatal Clinic Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: No maternal deaths reported during this period.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 SPM# 7. Please review your data to ensure this is correct

SPM 8 - The percent of one year old babies with anemia.

	2011	2012	2013	2014	2015
Annual Objective	20.0	10.0	15.0	16.5	16.0
Annual Indicator	30.5	42.6	45.2	35.2	
Numerator	922	135	188	152	
Denominator	3,024	317	416	432	
Data Source	Well Baby Clinic	Well Baby Clinic	Well Baby Clinic	Well Baby Clinic	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 9 - Percent of children 5-21 years old diagnosed with Rheumatic Fever

	2011	2012	2013	2014	2015
Annual Objective	20.0	20.0	25.0	19.0	18.5
Annual Indicator	29.6	3.0	19.8	5.4	
Numerator	79	428	85	83	
Denominator	267	14,315	430	1,526	
Data Source	Public Health Data	Public Health Data	Public Health Data	Public Health Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

None

Data Alerts: None

SPM 10 - Percent of Childbearing Women with Anemia, <35hct.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	5.0	17.0	16.5
Annual Indicator	6.0	19.3	17.2	18.3	
Numerator	767	770	590	650	
Denominator	12,766	3,992	3,421	3,554	
Data Source	Public Health Data	Public Health Data	Public Health Data	Public Health Data	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2011**

Field Note:
//2013// This is a New State Performance Measure that was added as a result of the 2010 Needs Assessment. Last year coverage was low because the data submitted did not cover for the entire year. The increase in this year's data reflects a full year of screening for the target population. //2013//

Data Alerts: None

Form 11

Other State Data

State: Federated States of Micronesia

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Federated States of Micronesia

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table