

**Maternal and Child
Health Services Title V
Block Grant**

Federated States of Micronesia

**FY 2020 Application/
FY 2018 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS

FSM National Government

Capital Street, P.O. Box PS 70

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Federated States of Micronesia

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July 9, 2019

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

Dear Sir or Madam:

FSM wishes to formally apply to the MCHB for continued funding under the MCH Services Title V Block Grant Program for fiscal year 2020 (October 1, 2019 to September 30, 2020).

The FY-2020 Application and FY-2018 Annual Report is submitted via the HRSA EHB.

We hope that the 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,

A handwritten signature in black ink, appearing to read "Marcus H. Samo".

Marcus H. Samo
Acting Secretary

Sent electronically:

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

I.E. Program Overview

The Federated States of Micronesia (FSM) comprises part of what was generally known as the Eastern and Western Caroline Islands. Some of the islands are volcanic and others are small atolls, except the state of Kosrae that doesn't have any other smaller atolls. The four FSM states are widely spread apart by the ocean, hundreds of miles from east to west. From farthest east is the state of Kosrae, which is more closer to the islands of the Republic of the Marshalls than to the islands of Yap, then going Westward to the states of Pohnpei, Chuuk, and farthest west is the state of Yap, which is more closer to the islands of the Republic of Palau than the rest of the FSM. The total distance across FSM, from east to west, is approximately 1,800 miles, the distance from Northern Maine to Miami and encompasses two time zones.

FSM has withstood the incursion of multiple cultures since the late 1800s from Spain, Germany, Japan, and then the United States that have led to social and economic changes. For example, until the introduction of foreigners, FSM people lived without the burden of NCDs, alcohol and other drugs. Recently, the FSM market's increased reliance on a cash economy has required a greater number of citizens to earn cash to buy basic services, such as transportation, groceries etc. These changes have resulted in more nuclear and less extended family structures and new gender roles.

In November of 2018, the FSM MCH Program under the FSM Department of Health Services, have received the award from the grantor- MCHB HRSA for the period of 2019 to 2020. The FSM Title V Program intends to use this current MCHB fund to continue with the MCH needs:

- Significantly reducing infant mortality;
- Providing comprehensive care for women before, during, and after pregnancy and childbirth;
- Providing preventive and primary care services for infants, children, and adolescents;
- Providing comprehensive care for children and adolescents with special health care needs;
- Immunizing all children;
- Reducing adolescent pregnancy;
- National standards and guidelines for prenatal care, safe child care, health supervision of infants, children, and adolescents;
- Assuring access to care for all mothers and children; and
- Meeting the nutritional needs of mothers, children, and families

The Federated States of Micronesia (FSM) Title V program is under the FSM Department of Health and Social Affairs (DHSA). The goal of the division of health services is to improve primary and secondary health care services, prioritize health promotion and services and develop sustainable health financing. One of the roles of the national division of health services is providing assistance to the state health services departments through funding and technical assistance.

The Family Health Services Unit housed the MCH program at the national Health Services Department. It is obvious that the Title V Maternal and Child Health Services Block Grant is the only program in the department that takes care of the four state MCH programs to strengthen maternal and child health services in their respective states.

The priorities for the FSM MCH population domains are still unchanged from previous year, but with minor modifications made in June 2019. Few updates were being made on the Priorities, ESM, SPM and Strategies. Below table shows the current Priorities, NPM, ESM and SPM that the FSM Title V program currently have and will continue to implement.

2020 FSM MCH Priorities & Plan				
Domain and State Priority Needs (SPN)	NATIONAL PERFORMANCE MEASURE	NPM Strategies	STATE PERFORMANCE MEASURE	SPM Strategies
Women/Maternal Health - NPM1				
<i>Priority 1. Improve women's health through cervical cancer and anemia screening</i>	NPM 1: Percent of women with a past year preventive medical visit	Conduct awareness workshops to 5 (each State) women's group ages from 15-65 years old on cervical cancer and anemia screening on an annual basis	SPM 1- % of women 21-65yo with VIA or PAP screening SPM 2 - % of women 15-44yo screen for anemia	Screen all women (child bearing age) in PH, Hospital,CHC, Dispensaries, schools, and outreach.
Perinatal - NPM4B				
<i>Priority 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</i>	NPM 4: Percent of infants breastfed exclusively through 6 months	Breastfeeding Support group to provide breastfeeding services	SPM 3 Percent of infants screened for hearing in 2019 SPM 4- Percent of pregnant women with first trimester prenatal visit	Work with state leaderships to have the hearing screening law pass in their respective states.
<i>Priority 3. Improve child health through vaccinations and screening for developmental delay</i>				
Child Health - NPM 13B				
<i>Priority 4. Improve oral health of children and Priority 5. Reduce childhood injury</i>	NPM 13:B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year	Increase the # of school visited to educate and provide preventive measures. (Varnish and sealant)	SPM 5 - incidence rate of 0-9 years old hospitalized for nonfatal injury/100,000	Do parental and community education campaign using visual aid radio, television and posters in prominent areas in the schools and communities
Adolescent Health - NPM 10				
<i>Priority 6. Decrease incidence of teenage pregnancy and STI</i>	NPM#10. Percent of adolescents, ages 12 to 17, with a preventive medical visit in the past year.	Provide educational awareness on sexual health (teenage pregnancy and STI) to adolescent ages 12-17 years old in all Public schools on main islands.		
Children with Special Health Care Needs - NPM 12				
<i>Priority 7. Provide a transitional services for youth identified as having Special Health Care Needs</i>	NPM 12: Percent of adolescents with or without special health care needs who received services necessary to make transitions to adult health care	Work collaboratively with DOE, IAC DOHSA or other NGO's to strengthen the non-medical related services for CSHCN youth for each States.		

The FSM MCH program aims to address the existing and updated priorities under the 5 MCH population domain: 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, hearing and anemia screening of the infant and promoting breastfeeding; Improve child health through providing vaccinations, screening for developmental delays, oral health for children and reduce child injury; Decrease incidence of teenage pregnancy and STI and Provide a transitional services for youth identified as having Special Health Care Needs. See (Supporting Document #1) completed Action Plan for 2020.

DOMAIN: WOMEN/MATERNAL HEALTH

Improve women's health through cervical cancer and anemia screening

Past Year Accomplishments: The FSM Title V program continue to provide cervical cancer screening and anemia screening to women of child bearing age (15-44 yrs old) in 2018. All of the four MCH programs in the FSM were able to utilize the E-pathology for Pap smears in Pohnpei and Japan. Collaborative efforts with other Public health programs and Community Health Centers are still in effect. Mass screening of Rheumatic heart disease was done in Pohnpei.

Challenges: Preventive health screening in the outer islands is still an issue, as there are limited staff and equipments to conduct the services. There were shortages of Midwife/Nurse practitioner in the OB clinics at the state hospitals. There was limitation in skilled staff to handle Pap smear specimen preparation to send off to the center for further examinations.

Plans: The FSM State MCH programs will continue to send Pap smear slides to Pohnpei for the E Pathology and Pap smear reading and result. FSM States plan to conduct awareness workshops to women's groups on cervical cancer and anemia screening on an annual basis. Screen all women (child bearing age) in PH, Hospital, Dispensaries, schools, and outreach. Actual activities on disseminating information on women's health will include text messages, radio announcement and other way of reaching the public for the annual events. The state MCH programs will conduct annual women's health event for cancer screening for cervical ca, breast cancer and anemia screening for all women ages 15-65 years old. MCH Program anticipates drafting Proclamation and having Governor of each FSM States to sign for all women in the Nation to join the event on Women's Health Day.

Domain: Perinatal/infant Health

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.

Accomplishments: There was an increase in the percentage of infant's breastfed exclusively through 6 months. Existing breast feeding support groups are either active, partially active and need reactivation in all the four FSM states. All the OB and MCH nurses trained and certified to do new born hearing screening, anemia screening and gestational diabetes screening.

Challenges:

- Most of the services (GDM test, STDs test,) that are offer in the main islands, are not offer in the remote dispensaries or outer islands
- Late booking and inadequate visit of pregnant mothers caused difficulties in monitoring their health status (diabetes, STDs, hypertension and etc)
- Most of the breastfeeding support group members are no longer active to provide breastfeeding services in the communities
- Shortage of staff nurses and nurse rotation in OB wards.
- Private clinics are not screening newborn for hearing loss.
- Customary adoption is another challenge.

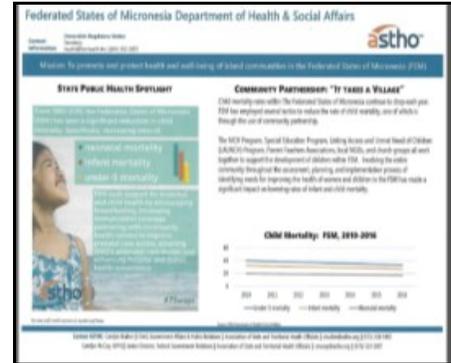
Plans: MCH programs will reactivate and recruit new members of the breastfeeding focus groups to implement the activities for the breastfeeding groups. There will be training to new members on counseling and services regarding breastfeeding. MCH programs at the state level will continue to do prenatal screenings on gestational diabetes, anemia and newborn hearing screening with collaborative efforts with the lab and other public health programs. Two state MCH programs will continue to work with their legislative leaders to pass the newborn hearing screening law in

their states.

Domain: Child Health

Improve child health through providing vaccinations and screening for developmental delays, oral health and reduce child injury

Accomplishments: There was mass campaign on MMR vaccination for the young children in the state of Pohnpei as well as the other three state MCH programs which they had their own immunization vaccinations in their respective states. Developmental screening was part of MCH programs' routine work through well-baby clinic hours along with some of the Community Health Centers in some of the FSM states. Awareness on road safety and injury prevention by the Public safety department was one major activity that was done by Information strategy mode. Curfew hours for children not roaming around public road after 9:30 pm were observed in most of the states. There was improvement on oral health care among children and the data shows an increase in the services provided in the past year. The Association of State and Territorial Health Officials (ASTHO) have recognized the efforts in the decreased on child mortality rates in the FSM which continues to drop from 2010-2016.



Challenges:

- Procurement of hearing screening supplies
- Shortage of staff affected developmental screening in the dispensaries
- Dental preventive care and children needing immunization are still activities/services that need to be stabilize.
- No developmental screening tools for above 18 months old babies

Plans: FSM MCH national program will continue to seek for tools and training on developmental delay screening tools above the 18-months old. Collaborative efforts will be continued with the Immunization programs to increase the coverage on children vaccination on Main Island as well as in the outer islands. Following are activities anticipated:

- Increase the number of dental staff in the dental clinic program
- Do parental and community education campaign using visual aid, radio, television and posters in prominent areas in the schools and communities.
- Develop brochures and poster addressing topics on childhood injury and distributed to the community.
- Do parental training on childhood injury prevention with other stakeholders.
- Work with public safety and other affiliated agencies on children injury preventive measures

Domain: Adolescents Health

Decrease incidence of teenage pregnancy and STI

Accomplishments: There was an increase in the number of schools in the FSM with the target age group (12 to 17 years old) that have received educational awareness on teenage pregnancy, STDs, alcohol and drug abuse and healthy lifestyles. MCH programs have collaborated with other Public health program to carry out the implementation on the strategy for this domain population.

Challenges: There are not enough curriculums on healthy adolescent behaviors that are included in the schools

curriculums and policies. Laws on reducing risk behaviors among adolescents are not fully supported and uplifted at the state levels. There is lack of youth friendly clinic services in the states.

Plans: Continue to provide educational awareness on sexual health (teenage pregnancy) to adolescent ages 12-17 years old in all Public schools on main islands.

- Collaborate with other public health programs (HIV/STI, PREP, Family Planning, etc.)
- Secure supplies and materials (IEC materials)
- Inform/meet with Director of DOE regarding the schools visits schedule and schedule meeting with the parents during PTA meeting
- To conduct a presentation on Teen pregnancy and STIs during PTA meeting
- Share strategies with the parents during PTA regarding the schools visits and get their consensus
- Presentations on the consequences on STI and teen pregnancy and preventive services available
- Distribution of IEC materials (brochures, and pamphlets)

Domain: Children and Youth with Special Health Care Needs

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

Accomplishments: FSM MCH continue to support CSHCN youth with special health care needs in their employment efforts. There was an improvement in the CSHCN registry that collects, store and analyze CSHCN data indicators for this population. There was an assessment on Rheumatic Heart Disease in one of the States which the outcome result enlighten the high officials on the significance of RHD screening, and is supported by the FSM national congress leaders by appropriating an amount specifically for RHD in children.

Challenges:

- Not all CSHCN children are in schools or enrolled at the Special Education program.
- There is no rehabilitation center where children can learn how to sew, cook, do gardening and build canoe, etc.
- No tracking data on transited CSHCN Clients
- Communities are not fully aware of the services available
- No such existing law regarding CSHCN youth becoming employee
- No Rehabilitation services where all this CSHCN youth that are not in school could register and get serve

Plans: Continue collaboration among programs, entities and community groups. Maintain collaborative efforts with families, CHC and dispensaries in all states. MCH programs will continue to strengthening awareness efforts in the communities on the availability and easy access of these health services to CSHCN youths. Work collaboratively with the NGOs, companies, churches, and other related services to help in serving this CSHCN youth.

Another suggestion from one of the MCH programs is to work collaboratively with DOE, DOHSA, NGO's and Interagency Committee/Stakeholders (IAC) to identify non-medical services and improve existing services to support programs to improve transition services to CSHCN youths.

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

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MCH serves the largest portion of the population in the state. The target population makes up of more than 55 % of the total population of the state. MCH program alone cannot realistically meet the needs of this target population. With the state's in-kind contribution such as; service providers, ancillary, laboratory, office space, utility, telephone, and transportation (field trip boat), off island treatments, MCH is able to provide services to its population. Therefore, the state program needs the assistance from both the federal agency and the state government to be able to deliver the needed services to the target population. MCH Program relies on the Title V Block Grant fund to support most of the operations, supplies and personnel of MCH Program. MCH Block Grant fund also support the special clinics (cardiologist team). All in all, the FSM MCH program relies heavily on the Title V Grant funds to implement most operational activities, to aim at achieving the FSM MCH goal and objectives in any given fiscal year. Should the federal funding on Title V funds ceases, the function of the MCH programs would be crippled.

III.A.3. MCH Success Story

III.A.3. MCH Success Story

Rheumatic Heart Disease

RHD screening project was carried out for the first time and allowed most of the children ages 5 -16 to be screened for RHD in the state of Pohnpei. The alarming results of the mass screening generated interest in other sister states and entities, most especially the Rotary Club of Pohnpei. Rotary Club of Pohnpei has donated 2 handheld portable echo machines (with backup battery) along with nearly \$10,000 worth of supplies (IEC materials, laptop, exam table and pulse oximeter) to assist the RHD screening in the state of Pohnpei. This club guaranteed to continue support the RHD screening in the coming years and is also looking into expanding their support to other interested FSM states as well.

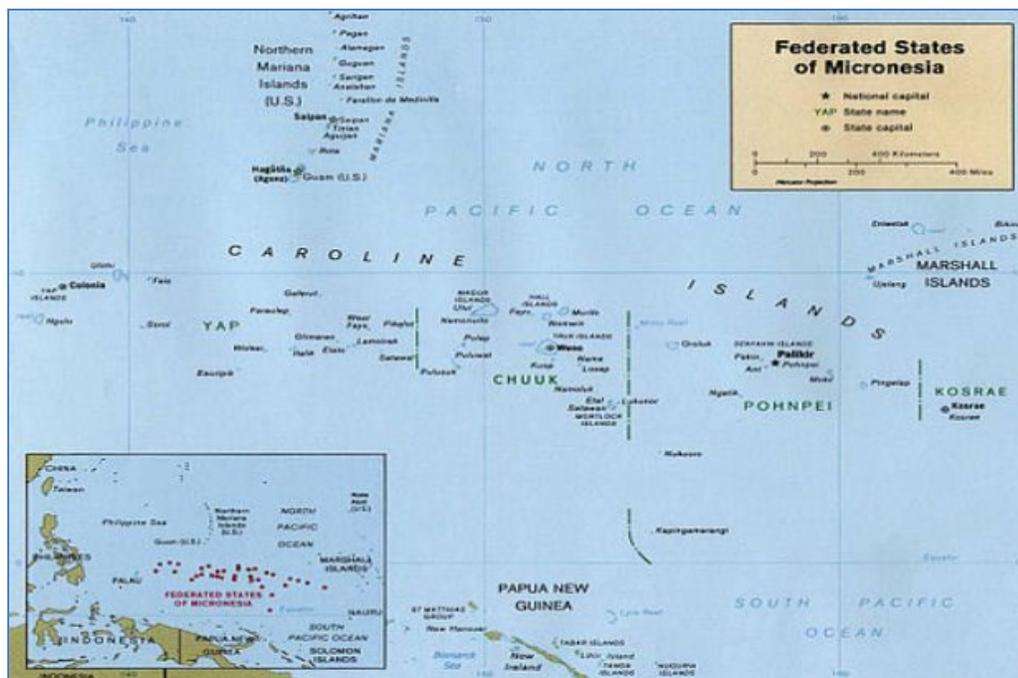
The RHD screening commenced on the 12th of March and lasted until the 6th of April, 2018. In general, the findings were consistent with what was found in most of the schools in Pohnpei. There is a huge problem with rheumatic heart disease in the State of Pohnpei. The State RHD rate is around 5%. This is comparable to other high prevalent countries around the world. The children with RHD have commenced on treatment and routine follow-ups after the mass screening.

III.B. Overview of the State

II.A. OVERVIEW OF THE STATE

Geography

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



https://en.wikipedia.org/wiki/Federated_States_of_Micronesia

Demographics

Below Table depicted the results from the 2010 Census which estimated 102, 843 persons residing in 16, 767 households in the FSM.

As mentioned in the Summary Analysis of Key Indicators from the FSM 2010 Census of Population and Housing, "While FSM population declined between 2000 and 2010, it is interesting to note that the number of households had increased from 15,723 to 16,767, an increase of 1,044 households. The average household size declined from 7 persons in 2000 to 6 person in 2010. Similarly, average family size declined from 7 in 2000 to 4 in 2010, indicating a preference for smaller families by couples in FSM".

Population by State (2010)			
	State Total	Male	Female
FSM Total	102,843	52,193	50,650
Chuuk Total	48,654	24,835	23,819
Kosrae Total	6,616	3,352	3,264
Pohnpei Total	36,196	18,371	17,825
Yap Total	11,377	5,635	5,742

According to the FSM Statistics 2010 Census Summary Report, it was stated that changes in the age and sex structure of a population are most effectively illustrated via what is called a population pyramid, but the overlaying population pyramid helps to identify unique population developments or demographic change by Comparing the 2010 0-4 year age group with the 10- 14 year age cohort of 2000, for example, indicates fertility has been declining; The higher proportion of 10- 14 and 15- 19 year olds in 2000 compared to 2010, points to high level of family migration out of FSM, and/or greater proportions of these age groups migrated outside for education or to seek work opportunities; and The change in population composition is most pronounced in relative terms amongst those in the older ages with 2010 numbers in the age-groups more than what they were in 2000.

According to World Bank, the FSM's demographic in 2016 and 2017 is depicted below:

Life expectancy: 69.20 years (2016) World Bank
Fertility rate: 3.14 births per woman (2016) World Bank
GNI per capita: 4,210 PPP dollars (2017) World Bank
Population growth rate: 0.6% annual change (2017) World Bank

The 2000 FSM Census of Population and Housing published in December 2002 for each FSM state provides evidence of the differences and similarities across the FSM states that had an impact on the implemented activities at the state and national MCH programs: At least 85% of citizens are native to the state in which they reside; more than 90% of citizens of each state prefer communicating in their state's native language (one of eight major languages in FSM); While English is the official language and is used in schools and government, the percentage of people who speak English averages 57%, with a low of 40% on Chuuk and a high of 75% on Kosrae; A high percent (averaging 49% across the FSM states) of citizens over 25 years of age do not have a high school diploma; The unemployment rates are high, ranging from 9% on Kosrae to almost 48% on Pohnpei. Concurrently, an average of 56.75% reported no income on the 2000 Census questionnaire; and the previously substantial job market for agriculture, forestry, fishing and quarrying have been replaced by Public Administration; Education; and Wholesale/ Retail Trades now employing the most workers.

Although there is the FSM National Constitution that holds the four FSM states together, each of the four states has its own state Constitution. Each of them replicates that of the national government with three branches of separate powers. Each of the FSM states has considerable autonomy and each one of them is equally unique in its own geography, ecology, language and cultures. Each state has unique cultural characteristics which are as important as the others. The cultural diversity is challenging and typified by the existence of eight major indigenous languages. However, with the existence of English language as the official language throughout the islands in the governments,

schools, and commercial businesses, it lessens the burden of not understanding one another when languages become the barrier.

System of Care Population Served

The 2018 FSM population projection estimates showed that there were 31,564 women of reproductive age (defined as women 15-44 years old). It was reported that about one fourth of the women of reproductive age had received direct services from the MCH programs in 2018.

2018 FSM POPULATION ESTIMATES			
Sex/Age	Total	Male	Female
Total	102,797	52,153	50,644
0 to 4	10,863	5,623	5,240
5 to 9	11,459	5,875	5,584
10 to 14	11,341	5,793	5,548
15 to 19	11,540	5,936	5,604
20 to 24	10,820	5,601	5,219
25 to 29	8,303	4,384	3,918
30 to 34	5,935	3,071	2,865
35 to 39	5,162	2,580	2,583
40 to 44	4,873	2,453	2,421
45 to 49	4,777	2,270	2,507
50 to 54	4,675	2,275	2,401
55 to 59	4,351	2,163	2,188
60 to 64	3,654	1,796	1,857
65+	5,042	2,335	2,708

Sources: FSM Census Population Projection

The number of infants (less than one year old) in the 2018 FSM population projection was 2,172. The 2018 population estimates shows that there were 22,322 children 1- 9 years of age. There were 22,881 children 10-19 years of age in the FSM. The MCH programs served 45,203 of these groups (0-19 years old) including the CSHCN population.

Government

The 21st Congress of the Federated States of Micronesia (FSM) began its first regular session on May 11, 2019 and on the same day elected the new president and vice president of the FSM. The new president is David W. Panuelo from the state of Pohnpei and also the 9th president of the Federated States of Micronesia. Yosiwo P. George from the island of Kosrae is re-elected as the vice-president for the nation.

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

them replicates that of the national government with three branches of separate powers. Each of the FSM states has considerable autonomy and each one of them is equally unique in its own geography, ecology, language and cultures. Each state has unique cultural characteristics which are as important as the others.

The four states are united and regulated under the FSM National Constitution. The Constitution provides separation of power of the three branches of government, the Executive, Legislative and Judiciary. Unlike the USA, most of the government functions are carried out at the state levels, except foreign policy and national defense are carried out at the national level.

People, Cultures, and Religion

People from the FSM are classified as people from Micronesia (The Micronesia region encompasses five sovereign, independent nations—the Federated States of Micronesia, Palau, Kiribati, the Marshall Islands and Nauru—as well as three U.S. territories in the northern part: Northern Mariana Islands, Guam and Wake Island) according to Wikipedia.org. Traditionally, like the rest of the Micronesians the FSM people rely on fishing and farming for subsistence. Skills such as

Woodcarving, traditional canoe and cottage constructions, fine weaving from hibiscus and coconut palms are regularly practiced and carried on as part of their traditional culture. The older people teach and pass them down to the younger generation.

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

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

Lanugage

The cultural diversity is challenging and typified by the existence of eight major indigenous languages in the FSM. However, with the existence of English language as the official language throughout the islands, in the governments, schools, and commercial businesses, it lessens the burden of not understanding one another when languages become the barrier. English is taught in the schools throughout the Islands in the FSM. Several older people speak Japanese, the language they learned during the Japanese Administration before the World War II.

Economy

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

Transportation

Nowadays people on the islands rely on vehicle transportation to go from one village to another and the only 2 national ships that provide services among the main islands and the outer islands. Shipping services to and from the four FSM States are provided by outside shipping companies like Kyowa Line from Japan, Mariana Express Lines Pte. Ltd. from Singapore and etc. The United Airline is the only commercial airline that provides flight services to and from United States of America to the four islands States via island hopper en route Guam five times a week.

Healthcare System

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

There are 5 Department of Health Services in the FSM; one national and four for the primary health agency for the four the States. The Health services are provided by the State Department of Health Services and other health programs; both primary and secondary health system of cares are made available through the State hospital only. Patients with complications or those requiring tertiary cares are referred off-island to Guam, Phillipines or Honolulu, depending on availability of funds provided by either the State governments or Micare Health Insurance.

General Health

According to the 2018 FSM BRFSS findings, more than 90% of the survey population reported that they have fair to excellent health. One out of ten individual respondents mentioned that they had 14 or more mentally unhealthy days during the previous 30 days.

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

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

Youth Suicide and Youth Mental Health in the FSM

Tragically, many youths struggling with mental health issues often turn to suicide; a trend Micronesian at-risk youth

coped with. Suicide is a sensitive subject in most Micronesian communities. Since the 1970's, Micronesia has had the highest suicide rates in the world as mentioned during the Youth International Day in 2014.

A large number of previous suicide studies incorporated the populations of the Micronesian community into very broad categories namely Asian Americans & Pacific Islanders. As a result of this ill defined categorization, we have unfortunately lost the capability of making importation differentiations between others & Micronesians as well as their various sub-groups within those populations. This has actually overlooked the diverse make up of the category of Pacific Islanders.

According to previous research, the incidence rates of completed suicide among the Pacific islanders including the Micronesian populations are some of the highest worldwide.

For the Micronesian populations specifically there is rather limited information on suicide data.

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

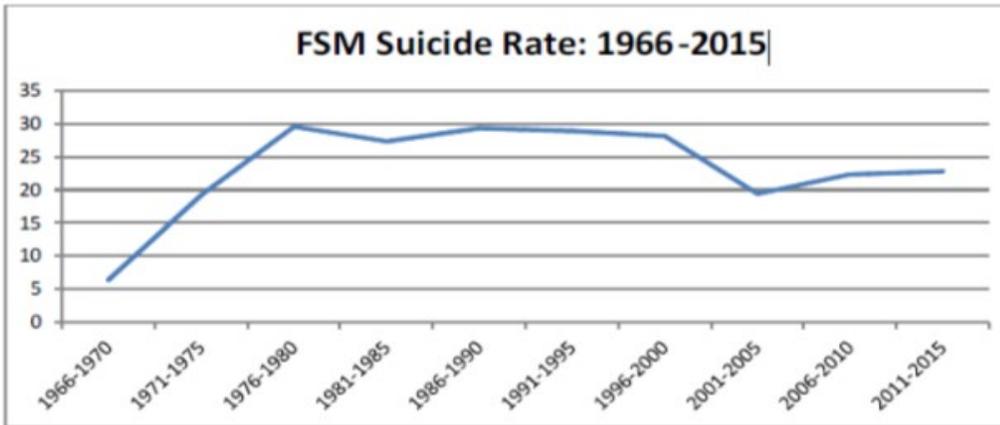
According to current FSM Behavioral Health & Wellness program Psychiatrist, Dr. Victor Wasson, he said "I feel that more of this much needed research is to be done in order to ensure that we establish prevention/intervention strategies that are culturally orientated/sensitive". He has stated that mental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

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

According to Dr. Wasson, the reasons for committing suicide are in the following:

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

Figure 1: Annual Suicide Rate (per 100,000) for FSM: 1966-2015



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

Emergency Preparedness

FSM has been the recipient of two cooperative agreements since 2004.

Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP)

The main functions of these cooperative agreements are preparedness and response planning.

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

PHEP has the following capabilities:

Domain	Capability and Tier
Community Resilience	Community Preparedness (Tier 1)
	Community Recovery (Tier 2)
Incident Management	Emergency Operations Coordination (Tier 1)
Information Management	Emergency Public Information and Warning (Tier 1)
	Information Sharing (Tier 1)
Countermeasures and Mitigation	Medical Countermeasure Dispensing and Administration (Tier 1)
	Medical Materiel Management and Distribution (Tier 1)
	Nonpharmaceutical Interventions (Tier 2)
	Responder Safety and Health (Tier 1)
Surge Management	Fatality Management (Tier 2)
	Mass Care (Tier 2)
	Medical Surge (Tier 2)
	Volunteer Management (Tier 2)
Biosurveillance	Public Health Laboratory Testing (Tier 1)
	Public Health Surveillance and Epidemiological Investigation (Tier 1)

HPP Capabilities are:

The Four Capabilities The four Health Care Preparedness and Response Capabilities are:

Capability 1: Foundation for Health Care and Medical Readiness

Capability 2: Health Care and Medical Response Coordination

Capability 3: Continuity of Health Care Service Delivery Goal of Capability

Capability 4: Medical Surge

Other Issues

FSM is tremendously experiencing adverse effects of climate change, very highly vulnerable to nature disaster, and that is another area that the nation is now focusing on to work with other governments and entities in strengthening resilience through disaster management.

Other barriers that all the MCH programs in the four States do encountered:

- Demographic Setting of the islands
- Transportation issues
- Need to improve on Public Education and Awareness
- Data collection from Outer Islands





III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

III.C. Needs Assessment

As usual, the annual MCH Workshop that is usually carried out in the spring of each year had taken place in June 2019 to continue to monitor the effectiveness of interventions that support improvements in the health, safety and well-being of the FSM MCH population. These efforts are led by the National and State MCH Program staff in partnership and collaboration with our Stakeholders.

The needs assessment update was always done annually by the states and also during annual MCH Workshop that was conducted in the state of Chuuk this year. The activities during the annual workshop were the review of the 2018 FSM MCH Data Matrix (Supporting Document #2). The state MCH Data Matrix, shows either the increase or decrease in the proportion of the population that received services from the MCH program in the past reporting year. The annual workshop served as a fundamental planning process for the whole needs assessment for the four state and national MCH programs.

The FSM MCH needs assessment for year 2018 was depicted in the following. This work was expanded on the data collection, analysis, and reporting efforts by the state and the national level related indicators.

State MCH Program Role	National MCH Role
<p><u>Data Review</u> Collected MCH data indicators:</p> <ul style="list-style-type: none"> • Census & Vital Statistics data • MCH clinical health records • Data records from other public health programs • Indicator data (courts, law enforcement, schools) • External programs that provide data on National Outcome Measures (health insurance) 	<p><u>Data Review</u> Assess MCH data and provide feedbacks to state MCH programs by:</p> <ul style="list-style-type: none"> • Compiling data records; • Cleaning and analyzing national data records •
<p><u>Program Inventory</u> Discuss following information:</p> <ul style="list-style-type: none"> • Frequency and dosage of MCH services • Populations served by the programs in terms of age and domain • Evidence-based measure use • Funding source • Potential for leverage with other existing PH programs 	<p><u>Program Inventory</u> Discussed:</p> <ul style="list-style-type: none"> • MCH program assets and resources; • gaps in services and capacity • Review of FSM national systems, policies, and funding streams that may directly or indirectly affect MCH program efforts.

The main source of data that the FSM MCH program continues to utilize to provide community context and inform

program priorities are the Hospital-based and Public health patient/client records, which is the only source of valid data that could be use as reference to any FSM health report in previous years. In 2018, the first FSM National BRFSS Comprehensive report is completed.

The following are major local data sources that the FSM MCH programs rely on and use:

- State MCH program patient encounter records,
- State Department of Health Services - state's vital statistics.
- Hospital databases - information around inpatient, outpatient and emergency visits.
- Behavioral Risk Factor Surveillance System (BRFSS) - administered by FSM Dept. of Health services.
- Other Public health programs - STI, Cancer, Immunization, etc.
- Micare health Insurance and Chuuk health insurance

The SSDI funding is paying 100% of the salaries for the four state data clerks collecting above data for the FSM MCH Title V program, and they are located in the four FSM MCH States. The national MCH program is focusing on collecting and integrating nationwide MCH data into a comprehensive resource management system housed at the national FSM MCH program. It is anticipated that the MCH data clerks will continuously collect and report all MCH data indicators for the FSM MCH program and also to highlight data trends and significances. These data will be used to inform updates and adjustments to program content and delivery to improve service effect to the MCH population domains.

State's MCH population Need:

Women/Maternal Health – The FSM projected Population in 2018 for this domain - women of reproductive age (15-44 years) was at 22,610 which represents about 47% of the state's female population. FSM title V program is directing the services for this domain mainly on preventive medical visit through cervical cancer and anemia screenings including all pregnancy care for the new mothers. There was decline over the years on cervical cancer and anemia screenings due to contributing factors. According to the 2018 FSM BRFSS it was shown that more than 3/4 of the women population did not have any healthcare coverage. Additionally, these uninsured women (84%) have reported that they have never checked their cholesterol and never had pneumonia vaccination during the past year.

Women of childbearing age (15-44 years) in the FSM do not always have access to high quality of preventive health services. Even though some improvement has occurred in reproductive health indicators over the past year, rates of morbidity and mortality remain high as a result of teenage pregnancies, high parity, poor birth spacing (less than 24 months between pregnancies), child-bearing complications, malnutrition, poor or non-existent prenatal care and late entry of expectant mothers into the health care system.

Perinatal/Infant Health – FSM projected population for this domain (<1 year old) was 2,172 which represents about 2% of the whole population. The FSM MCH program provided more than 90% of the perinatal/infant poulation. The focus for this group was on exclusive breastfeeding through 6 months period. However, there were no population based surveys done for this targeted group up to 2018.

Child Health – The projected population for children ages 1 through 21 in 2018 was approximately 60,000 which represents 58% of the total population. It was estimated that more than 35% of this population was being served by the MCH program. The FSM MCH program continues to help this domain population through preventive dental visit.

Recent Publication: Peer-reviewed publication in ASTHO (Maternal and Child Health Journal) – Child Mortality rates continue to drop in the FSM 2010-2016 - source WHO/FSM Dept. of Health Services

Adolescent Health – FSM projected population for adolescent was 22,881 represents about 22% of the FSM population. FSM MCH program is provided educational awareness on sexual health (teenage pregnancy and STI) to promote preventive medical visit to middle and high schools in the FSM States. FSM does not have any survey regarding adolescent health in this population domain.

Children with Special Health Care Needs – There were no evidence on the total population for this CSHCN group. The estimated registered CSHCN clients in 2018 were 1838 which shows 23% increased from CSHCN clients who are registered in 2017.

On-going Needs Assessment for the next 5 Years MCH Cycle:

The FSM MCH program has contracted AB Consulting, LLC to conduct the needs assessment for the next MCH funding cycle in the four FSM States. The timeline for the Needs Assessment is September 2019 to April 2020. All the four State MCH programs along with the national MCH program are ready and set for the needs assessment to take place in each of the four respective States.

FY 2019 Application/FY 2017 Annual Report Update

Needs Assessment Summary

Every five years, the Federated States of Micronesia (FSM) is required by the Title V legislation to develop a comprehensive statewide needs assessment. A comprehensive Needs assessment was conducted in 2015. 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 will continue to systematically assess needs during the upcoming two-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 2019-2020. As noted above, MCH resources will be allocated and/or shifted to implement the new priorities which will include ongoing evaluation.

An annual needs assessment update is conducted utilizing the annual MCH Workshop that is usually carried out in the spring of each year. These efforts are led by the National and State MCH Program staff in partnership and collaboration with our Stakeholders.

This year the FSM MCH Annual Workshop was held from April 30 to May 4 in Pohnpei State. Attending the workshop were FSM National Division of Health Unit Managers and other National Health Programs staff, FSM States' Public Health Program Coordinators and other hospital and public health staff, Women and Children's Physicians from the State of Pohnpei and State of Chuuk, Senior hospital and public health Clinical Nurses, MCH and Family Planning Data clerks, Parents of children with Special Health Care Needs from the four FSM States, Youth Group Representatives, Women Group Representatives, Church Group representatives from the Catholic and Protestant Churches in Pohnpei and other Stakeholders attended. Unfortunately, this year, the Division of Police and Security, Pohnpei State, did not send representatives to annual workshop.

The focus of this years' workshop was to review and revise the FSM 5 year Action Plan per the new Guidance issued by HRSA, MCHB. Although FSM understood that the current 8 NPM can be sustained, they opted to reduce the NPM from 8 to 5 to further reduce the work load. The main purpose of the workshop was to review FSM's MCH Program Action Plan, focusing on the existing 9 Program Priorities, 8 National Performance Measures, Strategies developed for the NPM, Evidenced-Based/Informed Strategic Measures and State Performance Measures, and activities for the purpose of further reducing the current 8 National Performance Measures to only 5 (1 NPM per Domain).

To do this the conference participants were grouped into 5 different work groups by MCH Population Domain. The groups were formulated through a head count of 1 to 5 having those participants who counted "1" in group #1; those counted "2" in group #2, and so on up to group #5. A MCH Program Coordinator chaired each of the first 4 groups and the Nurses Supervisor Pohnpei Division of Primary Health chaired the last group. This was a decision agreed to by the workshop participants. The task was to review the active Action Plan for each of the Domains and make recommendations for changes. For those domains that have two NPMs the group was advised to review and make recommendations for deleting one of the two. Afterwards, they were advised to review the Priorities, Strategies and ESMs relating to the selected/remaining NPM to determine whether or not additional changes are necessary. Determinants for change include complexity of Priority Area (statement addresses several and different health issues); relevancy of Strategy to the NPM and linkage to Priority Area, and that ESMs are able to measure change. They were advised, if necessary, to rewrite the strategies for the NPM, rewrite the Priority Statements to make it simple or more focused, rewrite ESM so they actually measure progress and develop State Performance Measure where the NPM does capture the priority need and at the end of the group work the groups reported out to the whole workshop. The results of the groups' work are mentioned in the State Action Plan Narratives.

This process allows others in the workshop to make observations, ask questions, and recommend for further changes.

Final activity of the annual workshop was the review of the FSM MCH Data Matrix (Supporting Document #1). Through the MCH Data Matrix, the State MCH Programs showcased their data matrices and presented on their program targets, accomplishments, challenges and plans for the next program period. The annual workshop 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 the next year.

The following table was the outcome result of the MCH Annual meeting for the 2019 Action plan for the next five years. (Supporting Document #2).

2019 MCH ACTION PLAN			
State Priority Needs (SPN)	NATIONAL PERFORMANCE MEASURE (NPM)	Evidence-based/-informed Strategy Measure (ESM)	STATE PERFORMANCE MEASURE (SPM)
Women/Maternal Health - NPM1			
Priority 1. Improve women's health through cervical cancer and anemia screening	NPM 1: Percent of women with a past year preventive medical visit	<i>Percent of women ages 15-65 years old received awareness workshop on anemia and cervical cancer screening</i>	SPM1: Percentage of women screen for anemia
Perinatal - NPM4B			
Priority 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 Priority 3. Improve child health through providing vaccinations and screening for developmental delays	NMP 4: B) Percent of infants breastfed exclusively through 6 months	<i>Percentage of 6 months old exclusively breastfed</i>	SPM 2: Percent of infants screened for hearing
Child Health - NPM 13B			
Priority 4. Improve oral health of children Priority 5. Reduce childhood injury	NPM 13B: Percent of children, ages 1 through 17 who had a preventive dental visit in the past year	<i>Percentage of children from K-5 to 3rd grader receiving dental awareness and dental services.</i>	SPM 3 Prevalence rate of 0-9 years old hospitalized for nonfatal injury/100,000
Adolescent Health - NPM 10			
Priority 6. Decrease incidence of teenage pregnancy and STI	NPM#10. Percent of adolescents, ages 12 to 17, with a preventive medical visit in the past year.	<i>Percent of adolescent ages 12-17 years received educational awareness for teenage pregnancy</i>	Percentage of adolescents ages 12-17 yrs. old receiving education awareness on STI.
Children with Special Health Care Needs - NPM 12			
Priority 7. Provide a transitional service for youth identified as having Special Health Care Needs	NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	<i>Percentage of CSHCN youth who ENROLL in the rehab program to receive the services.</i>	

FY2018 MCH TITLE V BLOCK GRANT APPLICATION SUMMARY STATEMENT

Recommendation: Although the Executive Summary is succinctly written and could serve as a stand along document, the FSM Title V program is encouraged to include highlights of accomplishments and successes in each population health

domain. Additionally, some discussions of emerging issues such as the recent onset of syphilis, and ongoing issue of anemia in the infant and women of child-bearing age populations, would add context to current and emerging issues.

Response: FSM was not very clear about what should go into the Executive Summary the last time the application was filed. Through the TA training in Honolulu in April this year FSM feel confident about what should be included in the executive summary statement for the 2019 application.

Recommendation: The FSM Title V program is encouraged to highlight unique priorities of the FSM in the FY2019 Application/Annual Reports, which allows for more flexibility, by developing state performance measures and ESMs to track strategies. Priorities that should be expressed in measurement as an NPM or SPM include childhood immunization, childhood injuries related to unsafe driving conditions, and increasing prevalence of Rheumatic Heart Diseases. Continuation with tracking of anemia in infants and women of child-bearing age is recommended. The FSM Title V program is also encouraged to explore developing strategies to address anemia in the adolescent female population.

Response: During the FSM MCH Annual Workshop held in May this year, the focus of the working workshop was to review and revise the FSM 5 Year Action Plan to respond to the Title V Program Requirements as well as to strength MCH services for mothers and children throughout our islands. In so doing NPM were re-evaluated and reselected, priorities were re-written for clarity and to have focus, strategies were also redirected and re-written to clarify target audience and services to be provided, objectives were re-written to be SMARY with annual targets that lead to the overall 5 year target, and SPM were developed to capture services that are not addressed in the NPM. FSM feels that we have addressed this issue adequately this year.

Recommendation: Although the Application/Annual Report describes a robust annual needs assessment process with input from stakeholders, it is not clear if there are additional opportunities for public and family input throughout the year. The FSM Title V program is encouraged to explore strategies for ongoing public input, if venues are not already available.

Response: The FSM MCH and Family Planning Annual Workshop, in addition to being used as a time when national and state public health programs and their colleagues, partners, and stakeholders meet to review progress, challenges and plan for the coming year, the annual workshop is also used as a venue where public input is solicited. The National MCH Program continues to encourage State programs to reach out through their partners and stakeholders to garner public input, even if inputs received are limited to their state's specific services, that should be sufficient. Stakeholders attending the annual workshop this year provided input to the process and content of the 2019 application. The application will be posted on the FSM Public Information Website for wider distribution.

Recommendation: In the State Action Plan, the Title V program is encouraged to provide clarification of NPMs matching ESMs. It appears that ESMs are written as proxy for NPMs. It is recommended that separate ESMs be written to reflect strategies and activities identified to address each NPM.

Respond: This recommendation has been address and corrected in the 2019 application. Please refer to 5 year Action Plan.

Recommendation: Although collaboration among the four state MCH coordinators, state partners and NGOs are commendable and a model for other jurisdictions, the Title V program is encouraged to further strengthen the partnership by engaging the four state health directors. The Title V program is encouraged to consider inviting the state health directors to participate in the annual MCH Workshop, and to the extent possible, participate in the annual Title V block grant application review. Their perspectives and leadership would further inform discussions.

Response: The National Government usually invites State Directors and Chiefs of Public Health Programs to the Annual Workshop but they felt that the activity is for program staff and therefore usually do not attend. The Directors would normally attend but for the opening and closing ceremonies, only. Most years, the Block Grant Reviews are held during the time when PIHOA or JEMCO are having their meetings in Hawaii, where FSM Health Directors also attend. They are aware of

the Block Grant Reviews but only 1 State Director has attended; Ms. Martina Reichhardt from Yap State. The National MCH Program will continue to extend invitation to State Directors and hopefully they will find the time and urge to attend.

All of the finding and recommendation made in the Review Summary Statement were put into consideration and incorporated into the development of the 2019 Grant Application.

FY 2018 Application/FY 2016 Annual Report Update

Needs Assessment Summary

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 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 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 2018-2020. As noted above, MCH resources will be allocated and/or shifted to implement the new priorities which will include ongoing evaluation.

A comprehensive Needs assessment was conducted in 2015. An annual needs assessment update is conducted utilizing the annual MCH Workshop that are usually carried out in the spring of each year. These efforts are led by the National and State MCH Program staff and a contracted consultant in partnership and collaboration with our Stakeholders.

The annual workshop was somehow exciting because this year was the first time that FSM MCH Program reported data on the Evidenced-Based Strategic Measures (ESMs) developed for each of the National Performance Measures (NPM) that corresponds to each of the Six (6) MCH Population Domains. It was the first time, also, for FSM to report on their New State Performance Measures. To facilitate the data reporting and review process, the MCH Data Matrix was pulled as the main document for program review (**See Supporting Document#1**). Through the MCH Data Matrix, each State MCH Programs showcased their data matrices and presented on their program targets, major challenges faced by their programs in the domain, accomplishments and major progresses on the National and Outcome Measures, and plan in the next program period for the progress of the priority areas. The annual workshop 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 the next year. FSM also employed a strategic planning process to examine how these changes can be incorporated into the existing MCH scope of work.

Data Findings

Women/Maternal Health: Despite the fact that all clinical sites perform preventive health exams, most women in the FSM start prenatal care late and most are not meeting the required number of prenatal visits. In 2015 only 25.8% of MCH women had a Pap smear. The percent of women who had a Pap smear increased to 26% in 2016. 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. 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. An assessment or review of prenatal care conducted during the MCH annual workshop showed that almost 70% of deliveries receive inadequate prenatal care. In 2016, about 41% 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 will prioritize and continue to strive to improve prenatal care adequacy in the coming year.

Perinatal/Infant Health: The perinatal mortality rate in the FSM in 2016 was 41.1 per 1,000 live births compared to 28.7 per 1,000 live births in 2015. In 2016, the percent of singleton births recorded in the FSM as having low birth weight was at 6.3%. The data continue to paint a scenario that unplanned pregnancy, late access and inadequate prenatal care, and poverty play a significant role in poor birth outcomes, causing additional stressors on the family, community, the health care system and the government. Lack of screening for gestational diabetes during prenatal care affects 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 2016, 69.7% 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 2016, 40.9% of infants up to 1 year old screened were anemic. However, that same year only 14.3% of the infant population was screened.

Child Health: Immunizations are a pillar of child health care. However, the overall coverage rates of immunization in FSM is quite low at 61.2% in 2016 a decrease from 62.7% in 2015. 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 2016 coverage was 97.6%. 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.

Adolescent Health: The FSM teen birth rate for 2016 was 23.5 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 2016, 11.2 per 1,000 women aged 15 through 19 years were reported with a case of Chlamydia. During the same year, 40.1 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 33.6/100,000 adolescents being reported in 2016. 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. The FSM MCH Program will continue to prioritize outreach activities targeting the schools throughout FSM focusing on ages 12 through 17 on issues discussed herein above.

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 2016, 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 9.3%. During the same year, the percent of CSHCN who received services necessary to make transition to adult life was reported at 18.1%. 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 operationalized. The 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 2016, 26.9% of children 1-5 years old were reported to have treated with fluoride varnish while 39.1% 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 finding of 0.8% in 2014 is quite low, but this does not assess tobacco use outside of smoking. In 2016 29% of women reported to have used tobacco during pregnancy. MCH Program intended to track and reduce not just smoking in pregnancy, but all tobacco use in

pregnancy.

FY2017 MCH TITLE V BLOCK GRANT APPLICATION SUMMARY STATEMENT

Findings: Although priorities were discussed in relation to NPMs and SPMs in the Executive Summary and challenges with women's health and infant/perinatal health domains are identified, there is no discussion of challenges or accomplishments for the four other population health domains.

Response: FSM has provided all necessary discussion including challenges and accomplishments for the remaining population health domains.

Findings: The improvement of telecommunication to address improvement of population health services is mentioned in the State Update, but it is not clear how the MCH program is planning to use telecommunication.

Response: Currently two hearing screening booths have been constructed for Pohnpei and Chuuk. Separate and dedicated high speed ADSL lines have been hooked up to these hearing screening booths. These booths will do tele-audiology and telehealth between overseas audiologist and specialist and public health staff in the FSM. The tele-audiology part has been tested in Pohnpei and it proved to be successful. The system can also be used for distance learning for Speech and Language Professional and Parent Support Group webinars. Video clips obtained during the pediatric cardiology clinics can be also uploaded using this system. This system can also be used for telehealth in country for example in Pohnpei with the WHO initiative Dispensary Strengthening Program, being pilot tested in Pohnpei with 3 Sites; 2 on the main island and 1 on the outer island of Pingelap.

Findings: After the conclusion of the June 2016 MCH workshop, MCH coordinators were asked as part of the needs assessment update to review the State Action Plan and strategies identified during the meeting, but only the state of Yap provided feedback. The lack of feedback from the other three FSM states, particularly from the most populous state of Chuuk, on the strategies identified for the health domains limits the value of results.

Response: There is nothing much FSM National Health department can do beside encouraging the States to solicit for public input. During the FSM MCH Annual Workshop the States were reminded again and were encouraged to solicit public input for the 2018 grant application.

Findings: It is not clear why there are two measures tracking newborn hearing screening, SPM#4, Increase newborns screened for hearing, and ESM #4.3, Percent of newborns with hearing screening prior to discharge.

Response: FSM already took out ESM #4.3 to resolve this finding.

Findings: The lack of capacity to conduct re-evaluation of children with special health care needs every 12 months is a concern. Although this re-evaluation was identified as a priority in the 2015 needs assessment, it is discontinued for the FY 2017 application due to lack of capacity.

Response: FSM rely on visiting specialists from overseas for re-evaluation, confirmation and in some cases screening for disorders. It was an oversight that re-evaluation was discontinued in 2017. FSM MCH Program will continue with re-evaluation of CSHCN in 2018. The interagency groups at State level will be strengthened for this purpose as well.

Findings: There are several financial reporting discrepancies for FY2015 expenditures. Specifically:

- The FY2015 expenditure notes an expenditure of \$82,599 for Form 2, Line 1A, Federal Allocation for Preventive and Primary Care for Children, which represents 16.3% of the Federal Allocation; Form 2, Line 1A, The federal expenditure for primary and preventive health care for children (\$82,599) does not equal the amount noted on the federal expenditure line for children on Form 3.1A.3 (\$42,198); Form 2, Line 1B, The federal expenditure for children with special health care (\$160,485) does not equal the amount noted on the federal expenditure line for children with special health care needs on Form 3.1A.4 (\$55,500).

Response: FSM has rectified and provided accurate financial information for 2016 into the application for 2018.

All of the finding and recommendation made in the Review Summary Statement were put into consideration and incorporated into the development of the 2016 Progress Report and 2018 Grant Application.

FY 2017 Application/FY 2015 Annual Report Update

Needs Assessment Summary

In 2015 the Federated States of Micronesia (FSM) did a Needs Assessment as 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. 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. 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 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.

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.

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 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. There were three major aspects identified in the prioritization process: magnitude, time trend, and severity. 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 selected areas for MCH investment, so that a comprehensive set of interventions could be employed at more depth to affect a five-year outcome. In addition, the chosen priorities needed to be tied to the MCH scope of influence in order to assure ultimate impact. To a degree that is stated, 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 next 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 (9) priorities.

The nine (9) priorities included: 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 delay; 4) Reduce childhood injury; 5) Provide a transitional services for youth identified as having Special Health Care Needs; 6) Improve identification of CSHCN through screening for developmental delays; 7) 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); 8) Improve oral health of children; 9) Reduce tobacco use in pregnant women.

FSM also selected eight (8) out of the fifteen (15) National Performance Measures to track for the next five years and they included: 1) Increase women receiving a well woman visit including Pap or VIA; 2) Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9; 3) Increase children receiving developmental screening; 4) Reduce rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9; 5) Increase CSHCN receiving transitional services; 6) Increase adolescents receiving a well visit; 7) Increase children receiving a preventative dental visit; 8) Decrease percent of women who use tobacco during pregnancy.

Realizing the dynamic nature of MCH as well as the depth and breadth of issues specific to these populations, in 2015 FSM developed a Work Plan with 9 Priorities, 26 Objectives and 64 Strategies that correspond to the National Performance Measures selected for the FSM for each of the six (6) Domains.

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 2017-2020. As noted above, MCH resources will be allocated and/or shifted to implement the new priorities which will include ongoing evaluation.

During the week of June 6-10, 2016 FSM had its MCH Annual Workshop in Yap State. The meeting brought together FSM National and State MCH Program Coordinators and staff, Physicians, Nurses, hospital and public health administrators and other public health program coordinators and staff from among the four States in the FSM. The purpose of the workshop was to review accomplishments and challenges for the past year, discuss current activities and plan for the coming year. This year's workshop was somehow challenging because FSM was to complete the development of the 5-Year Action Plan by developing Evidenced-Based Strategic Measures as well as identifying State Performance Measures with corresponding Objectives and Strategies for the next 5 years. To facilitate setting of targets for the National Performance Measures, National Outcome Measures, and State Performance Measures for the coming year, FSM needs to know exactly where we are at, in terms of meeting our long term targets at the end of the fifth year. To facilitate the review process, the 2011-2015 MCH Data Matrix was pulled as the main document for program review (*See attachment A*). Based on the review, we learned that FSM had made significant progress in some areas while there remain rooms for improvement in other areas. To facilitate the learning process bar and line graphs were developed for the National Performance Measures, National Outcome Measures, and the State Performance Measures showing the variations and trends over the five-year period. The purpose of the review was to determine how much FSM has achieved, during the past 5 years, in terms of meeting our priority targets. To do this, the team looked at and linked certain National Performance Measures with corresponding priorities to determine FSM's level of attainment after the fifth year. Because we were not comfortable in doing a statistical analysis and interpretation of the data as well as doing and determining the confidence interval of the data, due to the high variance of data reported during the years, FSM decided to determine and report on the average data for the 5 years.

Using the Average of the 5 past year data as benchmark for determining targets for the next 5 years (2016-2020) the

participants revisited and reviewed the objectives and strategies developed in 2015 for the eight (8) new National Performance Measures. The purpose of the review was to determine whether or not the objectives and strategies developed in 2015 were still valid and applicable to FSM given the revelation of FSM's level of achievements on the performance measures, targets, and priorities for the past program cycle (2011-2015) (See *attachment B*). Accordingly, the FSM team agreed to modify and update the objectives and strategies to facilitate development of Evidenced-Based Strategic Measures. In addition to updating the objectives and strategies for the National Performance Measures, FSM also developed five (5) State Performance Measures including objectives and strategies that link them to the national performance measure and the priority areas selected for each domain. The five (5) State Performance Measures included: 1) Increase women and infants screened for anemia; 2) Increase pregnant women screened for Gestational Diabetes; 3) Reduce infant/fetal death; 4) Increase newborns screened for hearing; and 5) Increase children receiving routine vaccines.

The week after the Annual Workshop the FSM National MCH Program staff sat down and reviewed the draft 5-year action plan developed in Yap State. The strategies developed for the 8 National Performance Measures were too numerous and almost unrealistic to identify evidenced-based strategic measures (ESMs) for them. The National team realized that some of the strategies that were developed for some of the State Performance Measures were already existed or were repeated for some of the corresponding National Performance Measures. Consequently, the draft 5 Year Action Plan was edited. As a result of the edits, final SMART objectives, strategies, and ESMs for the 8 National Performance Measures were finalized as well as objectives and strategies for the 5 State Performance Measures (*Please See attachment C for the Final 5 Year Action Plan*).

To ensure that the State MCH Programs contributed to the final Action Plan, the document was forwarded to all participants via email attachment with a request asking them to review and provide final comments before it was uploaded on the EHB. The States had a week to provide comments. Only Yap State provided comments by proposing to add a strategy on the use of Vaginal Progesterone but the national program staff felt that the strategy was already incorporated into the main document under the Infant and Perinatal Domain.

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

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 \geq 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. One of the main barriers to immunizations in the FSM is the need for refrigeration of the

vaccines, thereby making it difficult to provide to children of the outer and remote islands. This is apparent in the Kosrae specific data. Kosrae is a single island State. In this State without outer and remote islands 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 health 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 Tripler 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, Tripler 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 an 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.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$574,649	\$380,815	\$586,666	\$338,061
State Funds	\$440,000	\$467,000	\$440,000	\$300,000
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$1,014,649	\$979,569	\$1,026,666	\$638,061
Other Federal Funds	\$0	\$1,052,290	\$1,157,894	\$1,014,750
Total	\$1,014,649	\$2,031,859	\$2,184,560	\$1,652,811
	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$587,235	\$404,139	\$579,204	
State Funds	\$467,000	\$440,000	\$440,000	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$1,054,235	\$844,139	\$1,019,204	
Other Federal Funds	\$637,000	\$637,000	\$637,000	
Total	\$1,691,235	\$1,481,139	\$1,656,204	

	2020	
	Budgeted	Expended
Federal Allocation	\$569,064	
State Funds	\$440,000	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$1,009,064	
Other Federal Funds	\$598,000	
Total	\$1,607,064	

III.D.1. Expenditures

Expenditures:

In FY-18 FSM MCH Program received the Total Notice of Grant Award in the amount of \$517,973.00. During this grant submission, FSM spend the total amount of \$300,019.00. FSM will spend the remaining balance before the grant expire on September 30, 2019.

III.D.2. Budget

FEDERATED STATES OF MICRONESIA – FSM MCH BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2020

PERSONNEL \$23,417

A total of \$23,417 is requested to continue support the salary of the National MCH Program Manager. The total amount requested includes COLA and salary adjustment.

FRINGE BENEFITS \$2,909

A total of \$2,909 has been set aside for fringe benefits which cover social security, insurance and other benefits due the staffs. Fringe benefits are based at 13% of the total base salary.

TRAVEL \$27,934

A sum of \$27,934 is requested to fund program staffs at the national to conduct on-site program and fiscal monitoring in the FSM states. The Differences will support the travel of the National MCH Program Manager or staffs to attend the require MCHB conference and meetings as follow:

1). MCH Grant Review in Honolulu, Hawaii, 2). MCHB Partnership and Technical Assistance Meeting in Washington, D.C. and 3). MCH Epidemiology Conference in FY-2020.

EQUIPMENT \$0

No equipment requested in FY-2020.

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 \$1,050

A total of \$1,050 is requested to cover the FSM 2020 Membership fee to the Association of Maternal and Child Health Program (AMCHP).

OTHER \$ 1,000

A sum of \$1,000 will cover communication expenses, POL and freight.

TOTAL: \$56,810

PREGNANT WOMEN, MOTHERS & INFANTS BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2020

PERSONNEL \$117,721

The sum of \$117,721 has been budgeted to continue support the salaries of the component staff at the four (4) States of Kosrae, Chuuk, Pohnpei and Yap in FY-2020.

FRINGE BENEFITS \$13,896

Fringe Benefits for the States vary from 7.5% 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 \$13,896 in FY-2020.

TRAVEL \$13,098

This amount will cover intra-island travel to the outer-island to conduct outreach clinic and also attend the MCH Block Grant Review in Honolulu, Hawaii in FY-2020.

SUPPLIES \$12,649

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

EQUIPMENT \$0

No equipment funds requested in FY-2020.

CONTRACTUAL SERVICES \$6,370

This amount is requested to support Breast Feeding Support Group in the (4) FSM States.

OTHER \$7,000

This amount requested is to cover the cost of printing and reproducing MCH

Educational materials, communication, freight, petroleum, oil and lubricant (POL) in the four FSM States in FY-2020.

TOTAL: \$170,734

CHILDREN & ADOLESCENTS

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2020

PERSONNEL \$117,721

This amount requested will support the salaries of the component staff in each of the four FSM States in FY-2020.

FRINGE BENEFITS \$13,896

Fringe Benefits for the States vary from 7.5% 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 \$13,896 in FY- 2020.

TRAVEL \$13,099

This amount requested is budgeted for intra-island travels to the outer-islands to conduct outreach clinic and also attend the MCH Block Grant Review in Honolulu, Hawaii in FY-2020.

SUPPLIES \$12,649

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 \$0

No equipment funds requested in FY-2020.

CONTRACTUAL SERVICES: \$6,370

A total amount requested is to support breastfeeding support group.

OTHER \$7,000

A total of \$7,000 is requested to accommodate the costs of printing and reproduction, communication, freight, fuel, oil and lubricant for Chuuk, Kosrae, Pohnpei and Yap.

TOTAL: \$170,735

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2020

PERSONNEL: \$34,592

A total amount of \$34,592 is requested to continue support the salaries of the three (3) CSHCN Coordinators in the FSM States. (Chuuk=\$13,709, Pohnpei = \$9,845 and Yap = \$11,038 State.)

FRINGE BENEFITS: \$4,019

Fringe Benefits for the States Government vary from 7.5% 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 \$4,019 in FY-2020.

TRAVEL: \$50,000

\$50,000 will support off-island travel cost for the following program activities: 1) National MCH Program Manager and state MCH/CSHCN program staffs to attend 2020 FSM Interagency Agency Conference (IAC) in Kosrae; 2) the MCH Block Grant Review in Honolulu, Hawaii; 3). 2020 AMCHP Conference in Washington, D.C.; 4) 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 and 5) MCHB Partnership and MCH EPI-Conference in FY-2020.

SUPPLIES: \$52,174

\$52,174 is requested to purchase medical supplies such as long acting Bicilline, Multi

Vitamin, Albendazole and other medical supplies needed for the CSHCN program services in 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: \$20,000

A sum of \$20,000 is requested to support the CSHCN program activities in the four FSM States based on a proposal submission to the FSM National Government.

TOTAL: \$170,785

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2020

State of Chuuk

PERSONNEL: \$80,293

A total of \$80,293 is requested to continue support the salaries of the MCH Coordinators, one (1) graduate nurse, two (2) practical nurses, two (2) Health Assistants, one (1) health educator, one (1) MCH Secretary, one (1) Dental Assistant and one (1) Health Services Federal Program Coordinator. The total amount requested includes salary increase in FY-2020.

FRINGE BENEFITS: \$10,037

To cover the social security, insurance and other benefits due the staff, total of \$10,037 is budgeted based on 12.5% of the total base salary.

TRAVEL: \$7,620

\$3,000 is requested for intra-island travel to the lagoon and outer-islands to conduct outreach clinic. The differences amount of \$4,620 will support the travel of the MCH Program Coordinator or staff to attend the MCH Grant Review in Honolulu, Hawaii in FY-2020.

EQUIPMENT: \$0

No equipment funds requested in FY-2020.

SUPPLIES: \$5,000

a) Medical and Dental Supplies \$4,000

A sum of \$4,000 is requested to purchase medical supplies including prenatal tablets, iron tablets and liquid, multi-vitamins and tempra for children and to purchase laboratory supplies (Hemo-Q test kits) to screen 1 year old and pregnant women for anemia and Pap smears kit supplies. Another medical supplies needed to purchase are Topplers, toothbrushes, fluoride drops, sealants to run MCH clinics.

b) Office supplies (Expendable) \$1,000

A total amount of \$1,000 is requested to purchase office supplies to run MCH office activities.

CONTRACTUAL SERVICES: \$2,000

A total amount of \$2,000 is requested for contractual services. Of this amount, \$1,000 to support the breastfeeding support group and \$1,000 will be used to do a workshop to women's group to assist the program staffs in disseminating information (Health Education) in their own respective communities regarding issues that are related to women and children.

OTHER: \$3,000

A total amount of \$3,000 is requested for Printing and Reproduction; Communication, Petroleum Oil and Lubricant (POL) and Repair and maintenance of Program vehicle.

TOTAL: \$107,950

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2020

State of Kosrae

PERSONNEL: \$28,866

This amount requested is to continue support the salary of four (3) full time staff servicing MCH Program. This includes the MCH/CSHCN Coordinator, MCH Staff Nurse, and one MCH Dental Assistant.

FRINGE BENEFITS: \$4,330

Fringe benefit at the rate of 15% of the base salary is set aside for social security, insurance and other benefits.

TRAVEL: \$4,000

A sum of \$4,000 is requested to support the travel of the MCH Program Coordinator to attend the MCH Block Review in Honolulu, Hawaii in FY-2020.

EQUIPMENT: \$0

No equipment requested in FY-2020.

SUPPLIES: \$500

A total of \$500 is requested to purchase office supplies to support MCH program in the Center and out in the Fields.

CONTRACTUAL SERVICES: \$6,740

a) A sum of \$6,740 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: \$6,500

A sum of \$5,000 is requested to purchase medical supplies including prenatal tablets, iron tablets and liquid, multi-vitamins and tempra for children and also Pap smear Kit. \$1,000 for communication, printing, and reproduction and POL for outreach activities in the communities and \$500 to support the Breast Feeding Week.

TOTAL: \$50,936

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2020

State of Pohnpei

PERSONNEL: \$63,769

A total \$63,769 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, one (1) MCH Account Tech. II and one (1) Lab Technician.

FRINGE BENEFITS: \$8,736

This amount is based on 13.7% of the base salary for social security and other benefits due the staffs.

TRAVEL: \$7,400

\$3,000 is requested for intra-island travel to do an outreach clinic in the outer-islands. The differences will support the travel of the MCH Program Coordinator or staff to attend the MCH Block Grant Review in Honolulu, Hawaii in FY-2020.

SUPPLIES: \$15,000

a) Medical Supplies: \$12,000 is requested to purchase prenatal vitamins, iron tablets and liquid, multi-vitamin drops, Tylenol or Tempra liquid for the children and also pap smears kits.

b) Dental Supplies: \$2,000 is requested to purchase sealant, Etchant and fluoride varnish and other dental supplies needed for the program.

c) Office Supplies (Expendable): \$1,000 is requested to purchase office supplies and materials.

EQUIPMENT: \$0

No equipment funds requested in FY-2020.

CONTRACTUAL SERVICES: \$4,000

A total of \$4,000 is requested to support stipend of the breastfeeding support groups in the communities to provide awareness and monitor breastfeeding mothers up to 6 months.

OTHERS: \$3,000

A sum of \$3,000 is requested for Consumable Goods. a) \$500 for Communications; b) \$1,500 for Petroleum Oil and Lubricant (POL); and c) \$1,000 for printing educational materials.

Total: \$101,905

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2020

State of Yap

PERSONNEL: \$62,514

\$62,514 is requested to continue support salaries of seven (7) existing MCH staffs. One (1) MCH Coordinator, Three (3) MCH nurse, two (2) MCH dental nurse, and one (1) dental technician. FRINGE BENEFITS: \$4,689

Fringe benefit is based on 7.5% of the total base salary, which covers social security, Insurance and other benefits due the staffs.

TRAVEL: \$7,177

A sum of \$2,744 is requested for intra-island travel to conduct outreach clinics in the outer islands. The differences will support the travel of the MCH program coordinator or staff to attend the MCH Block Grant Review in Honolulu, Hawaii in FY-2020.

EQUIPMENT: \$0

No equipment funds requested in FY-2020.

SUPPLIES: \$4,798

a). Medical and Dental Supplies:

The amount of \$4,298 is requested to purchase medical and dental supplies including prenatal tablets, iron tablets and liquid, multi-vitamins and tempra for children, folic acid, sealants and fluoride and silver fluoride varnish and pap smear kits.

b). Office Supplies: \$500 is requested to purchase office supplies.

CONTRACTUAL SERVICES: \$0

No contractual funds requested in FY-2020.

OTHER: \$1,500

A sum of \$1,000 is requested to support printing of brochures for pregnant women and breastfeeding and to support the planned activities for awareness on teen pregnancy, breastfeeding and disability months. \$500 is to purchase Petroleum, Oil and Lubricant (POL), Communications and Utilities.

TOTAL: \$80,678

III.E. Five-Year State Action Plan

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

State: Federated States of Micronesia

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

[State Action Plan Table - Entry View](#)

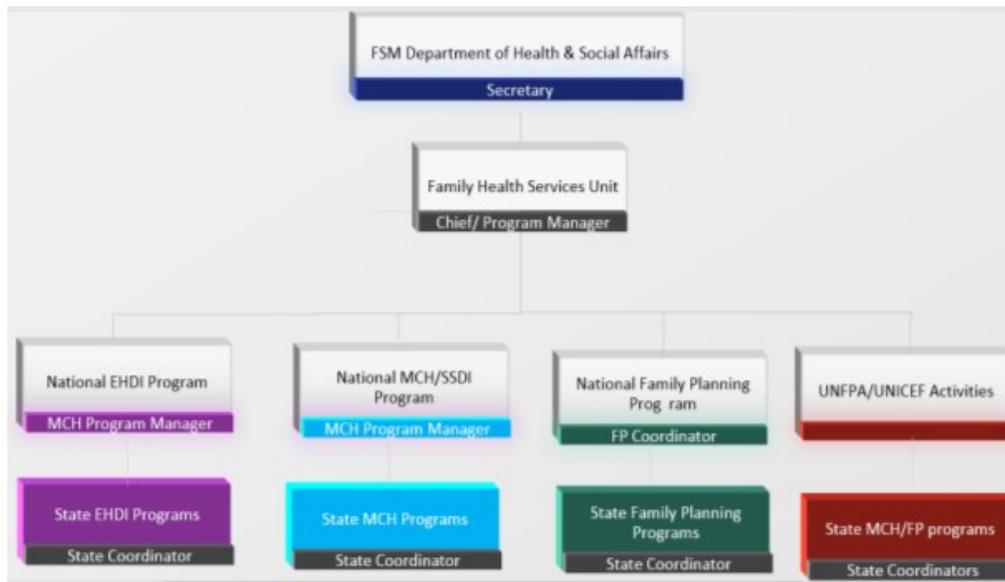
[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

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

The mission of the FSM Department of Health and Social Affairs is to promote and protect health and well-being of island communities in the FSM. Along with that purpose, the MCH Program envisions an island community where all mothers, infants, children aged 1 through 21 years, including CSHCN, and their families are healthy and prosperous in their life.



The above figure shows where the MCH Program is and the role it plays to transform the health of women and children in the FSM under the FSM Department of Health & Social Affairs.

The FSM MCH Program is the main Public Health program in the Family Health Services Unit that works with the other programs when it comes to implementation of activities. Each state program implements its own program at the state level and the FSM National simply guides, directs, and monitors their performance to ensure accountability and transparency of such federal programs.

Maternal & Child Health (MCH)

The FSM MCH Program has planned for and will continue to a community-based approach to the delivery of MCH program services and related preventive health services. This involves bringing maternal and child health services, health education and screening programs directly to residents of the areas. The services will continue to be conducted at public health clinics, community clinics, local parish halls, schools, community centers and sports facilities in close cooperation with more than ten local community organizations. FSM MCH program chose a conceptual framework that uses a primary prevention and early intervention-based approach with the goal of optimizing health and well-being among the MCH population across the life course, taking into account the many factors that contribute to health outcomes.

The impact of the MCH Block Grant funding and services reach far into the entire MCH Population in the FSM and further augment the way the health delivery system is structured to provide care.

Family Planning

The goal of the FSM Family Planning Program outreach plan is to provide individuals with information about the following subjects: 1) family planning benefits, 2) family planning services and methods and, 3) clinic locations, services, and hours. This is accomplished through a variety of promotional strategies. The Family Planning Title X

program continue to address issues relating to those women at risk by virtue of their age, parity, spacing, marital status and/or physical health, e.g. fetal deaths. FSM will implement the Title X Project Plan through a combination of direct service provision, increase capacity of primary care providers to deliver high quality reproductive health services, and increased community outreach and engagement.

Early Hearing & Detection Intervention (EHDI)

The FSM EHDI Program will implement the activities and strategies proposed in the grant to achieve the overall goal of which is to develop a comprehensive and coordinated statewide Universal Newborn Hearing Screening and Intervention (UNHSI) system of care targeted towards ensuring that newborns and infants are receiving appropriate and timely services, including screening, evaluation, diagnosis, and early intervention. There are three goals that lead to this overall goal: 1) increasing health professionals' engagement within and knowledge of the EHDI system, 2) improving access to early intervention (EI) services and language acquisition, and 3) improving family engagement, partnership, and leadership within the EHDI programs and systems.

UNFPA/UNICEF

With the Sustainable Development Goals (SDG), UNFPA works with the FSM Department of Health & Social Affairs to ensure universal access to sexual and reproductive health care services, including for family planning, information and education and the integration of reproductive health into national strategies and programs. Delivery of quality family planning and youth Sexual Reproductive Health (SRH) services are strengthened through provision of technical assistance to validate national family planning clinical protocols and provision of RHCS commodities.

The UNICEF assists the FSM by providing Vitamin A to (6-59 months) and Deworming to (12-59 months) for FSM.

III.E.2.b. Supportive Administrative Systems and Processes

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

III.E.2.b. Supportive Administrative Systems and Processes

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

There was no recruitment for MCH program personnel in 2018. There are 48 full time equivalent (FTE) staff working in the Family Health Services Unit at the national and state level which MCH program is part of. There are 34 staff that are getting paid by the MCH Program, 4 are getting paid by the SSDI grant, 18 are getting paid by the Title X Family Planning Program, and 2 are getting paid by the HRSA EHDI Program. These 52 employees working under the umbrella of the Family Health Services Unit that are counted under the workforce development for the Family Health Services Unit in the FSM of which the MCH Program is the overall head program for such programs.

Distribution of unit staff by State is as follow: See Table:

State:	Total Personnel:	Position/Discipline
FSM National Government	4 Employee's	1 Program Manager
		1 Program Coordinator
		1 Data Manager
		1 Financial Management Spec.
<hr/>		
Chuuk State	14 Employee's	3 Program Coordinator
		4 Practical Nurse
		1 Graduate Nurse
		2 Health Assistant
		1 Dental Assistant
		2 Health Educator
		1 MCH Data Clerk
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Pohnpei State	12 Employee's	2 Program Coordinator
		1 Follow up Coordinator
		2 Practical Nurse
		1 Dental Assistant
		1 Dental Nurse
		2 Health Assistant
		1 Asst. Health Educator
		1 MCH Data Clerk
		1 Account Tech II
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Yap State	11 Employee's	3 Program Coordinator
		2 Dental Nurse
		1 Dental Technician
		3 Practical Nurse
		1 MCH Data Clerk
		1 Peer Educator
<hr/>		
Kosrae State	7 Employee's	2 Program Coordinators
		1 Practical Nurse
		1 MCH Dental Assistant
		1 Outreach
		1 Peer Educator
		1 MCH Data Clerk
Total:		48 Employee's

Family Health Unit-Key Staff

The MCH programs at the state level are working within their scope with limited funding to hire more staff to assist in other areas pertaining to the MCH program. The staff are getting trainings in personnel management, data management, clinical management, clinical care and services, community relations and outreach, and are properly supported.

The FSM MCH program lack specialized skilled experts and specialty services to assist the targeted MCH

population domain in the four FSM States.

The FSM has been contracting Cardiologists from the Orange County Children's Hospital in California for over a decade now to provide Pediatric Cardiology Services for Children in the four states.

Several overseas contracts were made to hire experts who could do the work of an Evaluator, Audiologist and Speech Pathologist. Currently, FSM has two contracts executed for Arielle Buyum, Evaluator for the EHDI and Family Planning programs and Dr. Clare Camacho, a Speech Therapist from the University of Guam to provide Speech and Language Support to Children up to 3 years old who are deaf or hard of hearing and their parents. Dr. Camacho is also working with parents in each FSM State to identify parent leaders and help set up and implement learning communities in all States.

FSM Health department also have contracts with Shriner Children, Canvasback, and other visiting medical teams to provide specialized services in all FSM States. Other services were also provided by the US Military including audiology, dentistry and general clinics in selected FSM States .

E-Pathology Services in Pohnpei State enables Pap Smears, Sure path, and Biopsy to be read on-line and results provided to clients in a matter of few hours or a day, at the most. FSM entered into a MOU with a Pathology Lab in Hokkaido, Japan to read and confirm suspected Pap Smears for the FSM. All the FSM States have been utilizing this e-pathology service provided in Pohnpei state.

Despite the fact that recruitment is underway to recruit one or two lab technician and train them properly, the E-Pathology Project is operational and have cut back tremendous cost on overseas Pap smear reading contract fees and shipping of specimen overseas.

Since 2017, Training and education of the FSM MCH Workforce are still carried out at three levels: Onsite consultation, technical assistance and training; Regional and National Conferences; Local Workshops & Conferences.

The National MCH Coordinator travels to FSM States once or twice a year doing management training for the family health services unit staff MCH Program Coordinators, CSHCN Program Coordinators, Family Planning Program Coordinators and other public health program coordinators on how to effectively and efficiently implement the five-year action plan and engage stakeholders. The National System and Data Manager travels to FSM States once or twice a year doing training for the MCH Data Clerks, Family Planning Program Data Clerks and other public health programs' data clerks. The System and Data Manager also provided education and training on developing policy and procedures for data management, including data collection and cleaning, data analysis and interpretation, Quality assurance and Quality improvement and overall improving data capacity.

The National Financial Management Specialist travels to FSM States once or twice a year doing training in Miscellaneous Request Payments processing, Purchase Requisitions, Price comparisons, Reimbursements and Journal Vouchers, Preparing Personnel Action Forms, Account Reconciliation, and expenditure reporting.

Special trainings such as in-country and onsite training/retraining of public health nurses on Cervical Cancer using Pap smear and VIA; training of OB nurses in Early and Essential Newborn Care; and on-line continuing education courses from the Fiji School of Medicine and other institutions.

Organizational Structure – Although the FSM National Constitution holds the four FSM states together, each of the four states has its own state Constitution. Each of them replicates that of the national government with three branches

of separate powers. Each of the FSM states has considerable autonomy and each one of them is equally unique in its own organizational structure from the overall state composition down to the local municipality offices.

Staffing Structure – Different coordinators normally have different sets of values and therefore their priorities are not the same despite the fact that program guidelines and service protocols are in place. Re-organizing the public health programs into Units will strengthen collaboration, efficiency and effectiveness of programs services and wiser use of manpower and other resource. This concept also supports sustainability of specialized services and specialty care for families in the FSM.

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

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

Family Consumer Partnerships under the FSM Family Health Services Unit include:

MCH program and CSHCN families:

The Parent representatives from the four FSM States assist in the development of the work plan for the CSHCN Domain. Representatives of the office of Workforce Development Skills Program (WDSP) as an in-service for staff and parents to better understand the perspective of WDSP program and its role to facilitate Transition Program for CSHCN Youths in the one of the state - Pohnpei.

Immunization Programs:

MCH programs collaborate with the Immunization program in reaching out to families of infants and children for updating their immunization vaccinations.

Behavioral Health & Wellness programs: The MCH and Family Planning Programs partnered with the behavioral health and wellness program to conduct trainings and education to students 12-17-year-old regarding substance abuse including drugs, sexually transmitted Infections and other unhealthy and risk behavior affecting adolescents. This initiative is aimed at empowering young elementary and high school students to foster behavior change which yields positive health outcomes. Several of the efforts fall within the Child Abuse Prevention Planning Council & Behavioral Health Advisory Council.

Cancer Program:

Family leaders/partners participate on various committees, councils, and collaborative related to Family Health Services Unit programs including: Outreaches in the communities for awareness and actual activities on cervical cancer screening and breast examination.

Universal Hearing Screening Program:

The FSM Early Hearing Detection & Intervention program have the most involvement of Family Engagements including speech and language development and learning community representatives from the State programs and also other important affiliation groups such as the Inter-agency Councils (IAC).

Breastfeeding groups

Kosrae state in the FSM continue to utilize the breastfeeding support group members to do home visit follow ups and provide breastfeeding education at homes. The MCH programs along with the breastfeeding group maintain the work to strengthen breastfeeding policies within the government and private factors.

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.

The youth with special health care needs who are working in the private arena are part of the awareness on people with disability which involves partnership with private sector and non-governmental organizations.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The SSDI grant was mainly to supplement the MCH program data capacity and effort by improving the health information system infrastructure at the national and four state hospitals to standardize and formalize the design, recording, reporting and analysis of data at each State's hospital on inpatient, outpatient, pharmacy and related services. Following are general data system capacity that is in place and help shape the overall data system of the MCH program at the national and state level:

- Laboratory Information System (LIS) is the data collection in the Pohnpei State Hospital is fairly timely in its uploading of results on the system. The average time for results to be shown on the system varies according to the test. For instance, most blood workups and urinalysis non-stat results can be obtained within a couple of hours.
- WebIZ is a web-based data registry for Immunization program where registry of immunization clients takes place daily.
- All prenatal and antenatal data is entered onto Epi_Info data registry at the end of each patient visit (daily).
- FSMHER collects data on inpatient and outpatient hearing screening. Data entry is done on a weekly basis
- Other data source: Average of 2 weeks
 - Hospital Medical Record
 - Dept. of Education
 - Special Education
 - Early Childhood Education Program
 - MiCare Insurance
 - Department of Public Safety
 - BHW (LAUNCH project in Pohnpei)

There was maintenance and upgrades done in 2018 on the FSM Hearing Electronic Record or FSM-HER web-based system that improves the reporting portion. The recent fiber optic cables in Chuuk and Yap also boost up the FSM-HER system and enable instant access and faster data input and reporting from the two state MCH programs. Each year the National and State MCH Programs (family health unit and other public health programs) and stakeholders convene during the FSM MCH and Family Planning Annual Workshop where they meet and discuss accomplishments, challenges and plans for the coming year. While FSM works to have a web-MCH Module, data will continue to be collected, reported, and tracked through the Epi Info database system that was currently established for the MCH programs for decision making. The decisions and plans that go into the subsequent year application were informed by the data collected, reported and tracked through this Epi Info database system along with other database systems utilized by affiliated programs. The database system is being used by the National MCH Program and the four FSM States MCH Programs and Family Planning programs to collect register, and report program services activities including services for CSHCNs. Data collected through the Epi Info System have been generating data reports for this 2018 Annual Report and 2020 Application.

The FSM MCH program is continuing to work with the FSM-HER data system developer to create and establish the MCH modules in the FSM-HER system, so the MCH data can be collected and reported via a web-based system.

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

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

- The Health Care Delivery system involves a collaborative effort between the MCH Program and other Federal Programs providing preventive care services, (FP, Immunization, Tobacco, STI, and Cancer programs) to serve the MCH population domains.
- Contributions by NGOs and Faith Based Organizations also assist with the organization, dissemination of information, and recruiting of services providers.
- The State leadership has established policies and passed State laws to waive costs of health care for all MCH domains
- The overall goal for this collaborated effort is to ensure delivery of quality health care and needed services for the MCH population.

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

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

The FSM maternal health clinics serve as many women's first entry into medical care. The MCH 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.

For the FSM, federally funded programs' commodities and services are provided at no cost to the client. FSM has a Health Insurance Program known as "MiCare" Insurance Program. MiCare is optional for private businesses and State Government employees however it is mandatory enrollment of all National Government employees. In the current FSM BRFSS, it shows that among the 2,712 survey respondents, 71.3% of respondents said they did not have health-care coverage.

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

Specifically, at the State level, the Chief of Public Health supervises the posts relevant to all the public health program services: these include the STI coordinators, the Family planning coordinators, the MCH coordinator, the Adolescent health coordinators, Cancer program coordinators and all other public health program coordinators in all the states. Most of these posts are staffed by nurses who, in addition to coordinating and managing programs, also clinically manage patients and clients. The coordinators link with the community through the Community Health Centers (CHC) which is usually managed by doctors, nurses or health assistants. The CHCs provides general clinical and public health services including the provision of contraceptives, screening tests for pregnancy, cervical cancer and STIs including HIV, syphilis, gonorrhea and Chlamydia and treatment of STIs. When it is necessary, they referred patients to their counterparts in the Public Health Unit for more specific support relating to specific areas of expertise, as do each of the Coordinators.

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

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

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID	Data Not Available or Not Reportable	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	26.7	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	16.5	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID	Data Not Available or Not Reportable	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	14.9	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	20	30	78
Annual Indicator	26	76.3	73.8
Numerator	1,320	9,582	7,074
Denominator	5,080	12,556	9,589
Data Source	MCH program	MCH program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	85.0	87.0	90.0	95.0	97.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percentage of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		28	30	
Annual Indicator	26	21.6	25.3	
Numerator	1,320	1,637	5,728	
Denominator	5,080	7,584	22,610	
Data Source	MCH program	MCH program	MCH program and Census	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	32.0	35.0	38.0	40.0	45.0	50.0

State Performance Measures

SPM 1 - Percent of women (15-44 years old) screen for anemia for the past year

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		13	75	
Annual Indicator	15.1	69.5	19.4	
Numerator	615	5,272	4,384	
Denominator	4,064	7,584	22,610	
Data Source	MCH program	MCH program	MCH program and Census	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	27.0	33.0	38.0	43.0	50.0

SPM 8 - Percent of women 21-65 years old who have had VIA/PAP screening performed within the past year

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	20.0	25.0	30.0	35.0	50.0	

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Women/Maternal Health - Entry 1

Priority Need

Improve women’s health through cervical cancer and anemia screening

NPM

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

Objectives

By the end of FY2019, the percentage of women (21-65 years old) screen for cervical cancer (Pap/VIA) would be increased to at least 10% from the 50% (FSM benchmark) for the 5 years cycle.

Strategies

Conduct awareness workshops to 5 women's group ages (15-65 years old - one group from each municipality) on cervical cancer and anemia screening on an annual basis.

ESMs	Status
ESM 1.1 - Percentage of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening	Active
ESM 1.2 - Percent of Child bearing age women (15-44 year old) diagnosed with anemia	Inactive

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Improve women's health through cervical cancer and anemia screening

SPM

SPM 1 - Percent of women (15-44 years old) screen for anemia for the past year

Objectives

By the end of FY 2020 increase percentage of women ages 15-44 years old who were screened for anemia to 65%

Strategies

Screen all women (15-44 years old) at Public Health, Hospital, CHC, Dispensaries, Schools and outreaches

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

Priority Need

Improve women's health through cervical cancer and anemia screening

SPM

SPM 8 - Percent of women 21-65 years old who have had VIA/PAP screening performed within the past year

Objectives

By the end of FY 2020 increase the percentage of women (21-65 years old) who are screened for cervical cancer to 20%

Strategies

Screen all women (21-65 years old) in Public Health, Hospital, CHC, Dispensaries, Schools and outreaches.

Women/Maternal Health - Annual Report

Women/Maternal Health - Annual Report

Annual Report Fiscal Year 2018: This section provides a summary of FY18 activities, accomplishments, and challenges related to priorities, NPMs, and SPMs for the Women/Maternal Health Domain.

Priority: Improve women's health through cervical cancer and anemia screening. NPM 1: Percent of women with a past year preventive medical visit. Depicted below were directed activities done under women domain. In 2018, 15.6% of women attending MCH Program services had a Pap smear and those who had anemia screening were 59.5% during the same year. The target for 2018 is 40 percent. During this reporting period the cervical cancer screening is dropped by 6% mainly due to the closure of the Reference Laboratory in Guam where PAP smears from all the FSM States were sent to be read. This is the only Laboratory that FSM had a contract with so it took a while to find another Lab to contract.

Anemia screening is also dropped by 10% due to limited resources so screening is mainly in the clinical setting.

In June 3-7, 2019 the FSM MCH Annual Workshop was conducted in the State of Chuuk with all the State MCH coordinators and selected personnel from the state Department of Health Services and other affiliated health programs. Progress reports on some of the activities for this domain was discussed among the participants and most State participants reported that poor diet continue to be the cause of anemia for pregnant women. Multi-vitamins and ferrous sulfate were provided but the women often complaint about vomiting so they never follow through with the required course of medication. Cervical cancer screening is part of the information dissemination strategy that the MCH programs have been doing in their respective States. Nevertheless, some barriers were obvious for women of child-bearing age to reach the clinical sites to have a VIA or Pap smear done.

Regular screening of cervical cancer and anemia are done only in the center clinics on the main islands. Other dispensary outreach clinics were unable to provide screening services at the clinics in the communities during this period due to relocation to other sites. Awareness on the importance of cancer and anemia screening was still continued in the communities, Public Health clinics and during Health Events.

MCH DOMAINS	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>
WOMEN/ MATERNAL HEALTH DOMAIN				
Cervical Cancer Screening	25.8%	26%	21.6%	15.6%
Anemia Screening in Women of childbearing age (15-44 years old)	100.0%	100%	69.5%	59.5%

There is a significant drop in the maternal morbidity this year due to no cases reported from two (Kosrae & Yap) of the FSM States.

The maternal mortality rate is increased by 160.2 per 100,000 live births and this is due to the high risk mothers who live on the remote islands/Villages who came in late for delivery (when complications already set in)and without any prenatal care.

All low birth deliveries in 2018 were increased from 2017 low birth deliveries as shown in below table. The increase in LBW is most likely due to the poor nutritional status of the moms, high rate of infections that goes undetected and high teen pregnancy rate. Also high percentage of pregnant mothers started prenatal care late, mostly in the second and third trimester.

There were slightly changes in Preterm births in 2018. About 4-5% increase in infant and neonatal mortality occurred in 2018 due to poor nutrition, undetected infections and neglected early prenatal care.

NOMs UNDER WOMEN/MATERNAL DOMAIN	2017	2018
<i>NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations</i>	66.3	18
<i>NOM 3 - Maternal mortality rate per 100,000 live births</i>	51.4	211.6
<i>NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)</i>	6.5%	7.8%
<i>NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)</i>	0.2%	1.1%
<i>NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)</i>	6.4%	8.6%
<i>NOM 5.1 - Percent of preterm births (<37 weeks)</i>	3.0%	3.2%
<i>NOM 5.2 - Percent of early preterm births (<34 weeks)</i>	0.9%	1.1%
<i>NOM 5.3 - Percent of late preterm births (34-36 weeks)</i>	1.9%	1.4%
<i>NOM 6 - Percent of early term births (37, 38 weeks)</i>	12.1%	10.1%
<i>NOM 9.1 - Infant mortality rate per 1,000 live births</i>	15.9	20.6
<i>NOM 9.2 - Neonatal mortality rate per 1,000 live births</i>	11.3	16.9
<i>NOM 9.3 - Post neonatal mortality rate per 1,000 live births</i>	4.6	3.2
<i>NOM 9.4 - Preterm-related mortality rate per 100,000 live births</i>	668.7	687.8

Challenges:

All Pap smears were sent to the Histo-pathology technologist who does the reading of the Pap smears in Pohnpei State alone. Due to limited man power and skills to handle the specimen from the other three States, the turn-around on the results were mostly negative, and the States MCH staff and physicians did questioned about the results. Two of the States reported that some of the negative results were actually positive when their patients went to the Philippines or Hawaii on further health examinations and were confirmed of cervical cancer. Several of the barriers were transportation, baby sitter, and etc.

Women/Maternal Health - Application Year

Women/Maternal Health - Plan for the Application Year:

This section presents strategies/activities for 2020 MCH priorities related to Women/Maternal Health.

FSM MCH priority one is addressed in the Women/Maternal Domain including: Improve Women’s Health through Cervical Cancer screening and Anemia screening which is linked to NPM 1 as proxy: Percent of women with a past year preventive medical visit.

Domain and State Priority Needs (SPN)	NATIONAL PERFORMANCE MEASURE	Objective	NPM Strategies	Evidence-based/-informed Strategy Measure (ESM)	ESM Numerator/ Denominator	STATE PERFORMANCE MEASURE	SPM Strategies
Women/Maternal Health - NPM1							
Priority 1. Improve women’s health through cervical cancer and anemia screening	NPM 1: Percent of women with a past year preventive medical visit	1. By the end of FY 2020 increase the percentage of women (21-65) who are screened for cervical Ca screening to 20 %.	Conduct awareness workshops to 5 women’s group ages from 15-65 years old (1 group from each municipals) on cervical cancer and anemia screening on an annual basis	<i>Percent of women ages 15-65 years old received awareness workshop on anemia and cervical cancer screening</i>	Number of women ages 15-65 years received awareness workshop on cervical cancer and anemia	SPM 1- Percentage of women 21-65yo who have had VIA or PAP screening performed within the past 12 months SPM 2 - Percentage of women 15-44yo screen for anemia during the past 12 months	Screen all women (child bearing age) in PH, Hospital,CHC, Dispensaries, schools, and outreach.
		2. By the end of FY 2020 increase the percentage women 15-44yo who were screened for anemia to 65%			Total Number of women ages 15-65 years old in the state		

During the June 3-7, 2019 MCH Annual meeting, all participants came into an agreement that since the 2019 objectives and activities under the Women domain were not fully met in year FY2018, the State MCH programs will continue to implement the activities in FY2019-2020.

The FSM MCH program updated the existing NPM strategy of conducting 20 awareness workshops (5 from each State) to women’s group ages 15-65 years old on the importance of cervical cancer and anemia screening on an annual basis. In order to carry out the strategy, meeting will be conducted to all MCH staff, O.B Gyn, Midwives, P.H. staff, CHC staff in planning and setting on the dates, budget, resources, etc of the workshops. This will involve community leaders (mayors, faith groups, Women’s groups) to assist in organizing and announcing the workshops.

Actual activities on disseminating information on women's health will include text messages, radio announcement... etc for the annual event. Conduct annual women’s health event for cancer screening for cervical ca, breast cancer and anemia screening for all women ages 15-65. Draft Proclamation and have Governor of each FSM States to sign for all women in the Nation to join the event.

The SPM strategy is to Screen all women (child bearing age) in PH, Hosp, CHCs, Dispensaries, Schools and outreaches including women’s health month annually.

Activities:

1. Provide refresher trainings to the health providers; (CHC's, dispensaries) 3-5 days to expand services to the community level.
2. Continue to screen for cervical cancer and anemia to all women (CBA) in P.H., Hosp, CHC'S, dispensaries, Schools and outreaches in all for states.
3. Preparation of supplies needed; such as; pap kit, staff, hem cue machine, curettes, examining tables, examining lamps, fixatives, etc.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	26.7	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 4

National Performance Measures

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

NPM 4A - Percent of infants who are ever breastfed

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	85.0	90.0	95.0	100.0	100.0	100.0

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

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	78.0	80.0	83.0	85.0	88.0	90.0

Evidence-Based or –Informed Strategy Measures

ESM 4.2 - Percent of six months old exclusively breastfed.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		73	65	
Annual Indicator	69.7	59.4	70.7	
Numerator	1,359	1,155	1,336	
Denominator	1,950	1,944	1,890	
Data Source	MCH program and Birth Certificate	MCH program and Birth Certificate	MCH program and Birth Certificate	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	80.0	85.0	90.0	92.0	95.0

State Performance Measures

SPM 4 - Percent of infants screened for hearing

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		83	76	
Annual Indicator	79.1	73	79.9	
Numerator	1,599	1,512	1,589	
Denominator	2,021	2,072	1,989	
Data Source	EHDI program and Vital stats	EHDI program and Vital stats	EHDI program and Vital stats	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	85.0	90.0	95.0	100.0	100.0

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	60.0	70.0	80.0	90.0	95.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Perinatal/Infant Health - Entry 1

Priority Need

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

NPM

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

Objectives

By 2019, increased percentage of infants exclusively breastfed up to six months old by 15%

By 2019, 100% of all babies born at the hospital will be breastfeeding upon hospital discharge.

Strategies

Breastfeeding support groups to provide breastfeeding services in the communities

ESMs

Status

ESM 4.1 - Percentage of pregnant women diagnosed with gestational diabetes

Inactive

ESM 4.2 - Percent of six months old exclusively breastfed.

Active

ESM 4.3 - Percent of newborns with hearing screening prior to discharge

Inactive

NOMs

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

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

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

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

Priority Need

Improve child health through providing vaccinations and screening for developmental delays

SPM

SPM 4 - Percent of infants screened for hearing

Objectives

By end of fiscal year 2020, 90% of all newborns will be screened for hearing.

Strategies

Work with state leaderships to have the hearing screening law pass in their respective states.

State Action Plan Table (Federated States of Micronesia) - Perinatal/Infant Health - Entry 3

Priority Need

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.

SPM

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

Objectives

By end of 2020, increase percentage of first trimester visits to 30%

Strategies

Provide prenatal awareness in the communities

Perinatal/Infant Health - Annual Report

Perinatal/Infant Annual Report

Annual Report for Fiscal Year 2018: This section provides a summary of FY18 activities, accomplishments, and challenges related to priorities, NPMs, and SPMs for the Perinatal/Infant Health Domain.

Priority: 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. NMP 4: B) Percent of infant's breastfed exclusively through 6 months. There was an increase of 16% of exclusively breastfed through 6 months compared to 2017 data. The target for 2019 is 65 percent. Although there seems to be an increase in 2018, yet, three States actually had a decrease in this NPM and one State (kosrae) had the highest percentage of breastfeeding exclusively through 6 months.

Gestational diabetes screening FSM MCH programs continue striving to improve perinatal outcome thru Gestational Diabetes. Data showed an increase of 4.4% from 2017 data on pregnant women diagnosed with gestational diabetes. The increase is mainly due to increase awareness on healthy food and healthy behaviors. Another reason was due to the NCD declaration in all the FSM states calling for all states to decrease incidence of NCDs.

FSM MCH programs continue striving to improve infant health through:

1. Anemia screening

2018 data showed a decrease of 9.2% of infants less than 1 year old screened with anemia from 2017 data and an infant diagnosed with anemia was 14.4% in 2018 and 16% in 2017. Screening was low in 2018 because not many children are sick. Infants diagnosed with anemia was low due to increased in exclusive breastfeeding, increase awareness on benefits of breastfeeding and ENC- Essential newborn care regarding delayed in cutting of the cord after birth which prevent anemia before one year old.

2. Breastfeeding up to 6 months

There was an increase of 76.4% in 2018 from 60% in 2017, and this was usually due to the increase awareness on benefits of breastfeeding and active support group (kosrae) that provide support and counseling to the mothers.

3. Hearing screening

The decrease on hearing screening in 2018 was directly from the rotating of nurses in the wards. New nurses hired were not properly trained for hearing screening, thus letting infants left without screening. One of the States reported on broken corti-machine, and all the States did report on Nurses' attitude toward hearing screening.

FSM 2018 data showed an increase of 20.6% in the rate of infant mortality from 15.9% in 2017. Although newborn care have improved in all the States, still more infants died due to infection, poor nutritional status and premature birth. With all the awareness effort on improving child and mother's health, many pregnant women continued to chew betel nuts which decreased their appetite, drink sakau and coming late for prenatal care leaving insufficient time to treat/managed problem and malnutrition in the older age.

MCH DOMAINS	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>
PERINATAL HEALTH DOMAIN				
Gestational Diabetes Screening	na	0.5%	11.4%	15.8%
Anemia Screening (number of < one year olds)	26.1%	14.3%	23.6%	14.4%
Breastfeeding up to six months	60.0%	69.7%	60%	76.4%
Hearing Screening	77.3%	79.1%	90.0%	79.9%

In 2018 the data showed a decrease in post neonatal mortality rate from 4.6 in 2017 to 3.2. This is mainly due to increase in breastfeeding and improved newborn care. New born mothers are strictly stay at home all the time and adhering to their newborn babies up to one year. Family members and extended families played an important role in rearing the new born mothers and babies.

NOMs - PERINATL/INFANT DOMAIN	<u>2017</u>	<u>2018</u>
<i>NOM 9.1 - Infant mortality rate per 1,000 live births</i>	15.9	20.6
<i>NOM 9.3 - Post neonatal mortality rate per 1,000 live births</i>	4.6	3.2

Challenges:

- Most of the services (GDM test, STDs test,) that are offer in the main islands, are not offer in the remote dispensaries or outer islands
- Late booking and inadequate visit of pregnant mothers caused difficulties in monitoring their health status (diabetes, STDs, hypertension and etc)
- Most of the breastfeeding support group members are no longer active to provide breastfeeding services in the communities
- Shortage of staff nurses and nurse rotation in OB wards.
- Private clinics are not screening newborn for hearing loss.
- Customary adoption is another challenge.

Perinatal/Infant Health - Application Year

Perinatal/Infant Health - Plan for the Application Year:

FSM MCH priorities is addressed in the Perinatal/Infant Domain: 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.

FSM MCH program will continue to implement NPM 4B - Percent of infants breastfed exclusively through 6 months and the two selected SPMs: Percent of infants screened for hearing and Percent of pregnant women with first trimester prenatal visit

The existing strategy for NPM 4B is Breastfeeding support group to provide services in the communities. MCH programs will reactivate and recruit new members of the breastfeeding focus groups in the other 3 States to carry out this activity. These breastfeeding groups will be targeting each municipal at a time (pohnpei, chuuk & yap). There will be training to new members on counseling and services regarding breastfeeding. In the State of Kosrae, breastfeeding groups are very active because they were contracted by the MCH program and have updates on what should be done to improve the work assigned by the MCH program. The other States are also interested and will adapt what Kosrae is doing on breastfeeding group by providing incentives (stipend)/ or contract to members of the breastfeeding group.

The SPM strategy is to have hearing screening law pass in each state. Two states have their hearing screening law passed by in previous years. Chuuk and Yap states are still lobbying for their legislature to pass their hearing screening law. Staff are being proactive in following up with their State legislatures office on the status of the hearing screening bill.

Domain and State Priority Needs [SPN]	NATIONAL PERFORMANCE MEASURE		Strategies	Evidence-based/ informed Strategy Measure (ESM)	ESM Num/Denom	STATE PERFORMANCE MEASURE	SPM Strategies
Perinatal - NPM4B							
<p><i>Priority 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 /</i></p> <p><i>Priority 3. Improve child health through providing vaccinations and screening for developmental delays</i></p>	<p>NPM 4: Percent of infants breastfed exclusively through 6 months</p>	<p>By end of 2020, increase percentage of infants exclusively breastfed up to 6 months to 80 %</p>	<p>2. BREASTFEEDING SUPPORTS GROUP TO PROVIDE BREASTFEEDING SERVICES IN THE COMMUNITIES</p>	<p>Percentage of 6 months old exclusively breastfed</p>	<p>Number of babies having 6 month old well baby visit in MCH clinics in 2019 who were noted to be exclusively breastfed</p>	<p>SPM 3 Percent of infants screened for hearing in 2019 SPM 4- Percent of pregnant women with first trimester prenatal visit</p>	<p>Work with state leaderships to have the hearing screening law pass in their respective states.</p>
				<p>Number of babies having 6 month old well baby visit in MCH clinics in 2019</p>			

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH	Data Not Available or Not Reportable	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 13.2

National Performance Measures

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

NPM 13.2 - Child Health

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	27.0	35.0	40.0	50.0	60.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		15	50	
Annual Indicator	9.4	46.9	0	
Numerator	1,861	4,701	0	
Denominator	19,766	10,020	100	
Data Source	Dental program and Census	Dental program and Census	Dental program and Census	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	40.0	50.0	60.0	70.0	80.0

State Performance Measures

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	500.0	400.0	300.0	200.0	100.0	50.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Child Health - Entry 1

Priority Need

Improve oral health of children

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By end of 2019, number of children (K5 to third graders) receiving preventive dental services will be increase by at least 15%.

Strategies

Increase the number of K5-3rd graders who received preventive dental measures (varnish and sealant).

ESMs

Status

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Active

NOMs

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

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

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

Priority Need

Reduce childhood injury

SPM

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

Objectives

By December 2020, enhance collaboration with Public Safety, NGOs and community groups on the awareness on child injury prevention.

Strategies

Do parental and community education campaign using visual aid, radio, television and posters in prominent areas in the schools and communities.

Child Health - Annual Report

CHILD Health - Annual Report

Priority: Improve child health through vaccination, developmental delay screening and Reduce childhood injury.

There was a dropped on completed vaccination in up to 2 years old data in 2017, but in 2018 it spiked up again to 61% an increase of about 6%. The increase is due to more immunization campaign, additional immunization staff, outreaches and collaboration between Public Health Programs and the external partners.

Percentage of developmental delay screening increases to 8.2% in 2018 from 6.4% in 2017 due to more collaboration and more screening activities such as child find survey and outreach activities.

The Rate of Childhood injury is increase to 665/100,000 in 2018 from 158.2/100,000 in 2017 due to the increase of awareness and referral from the dental programs. Initiation of prevention awareness groups such as CHC, CWC, domestic violence and youth groups contributed to lower cases of child injuries.

There is an improvement on oral health and it was increase by 11.1% in 2018. Collaboration between the Oral Health Program and MCH Program is very good and it resulted in more children getting preventive dental care. Oral Health services are always accessible.

MCH DOMAINS	2015	2016	2017	2018
CHILD HEALTH DOMAIN				
Completed Vaccination - up to 2 years old	62.7%	60.7%	55.1%	61%
Developmental delay Screening (0-9 yrs. old)	7.5%	7.1%	6.4%	8.2%
Reduce Child Injury (0-9 years old)	590/100,000	361.3/100,000	158.2/100,000	665/100,000
Improve oral health (1-5 years old - varnish/sealants)	37.8%	9.4%	19.5%	30.6%

The Rate of Child Mortality decreased to 68.9 in 2018 from 91.2 in 2017 due to increased preventive activities such as Immunization, Nutrition, Antenatal and awareness and also there are new pediatricians on board, especially Kosrae and Chuuk.

Percent of Children in excellent or very good health is increased to 38.5% in 2018 from 36.9% in 2017. It was obvious that breastfeeding and nutrition services contributed a lot to the health of a growing child. For example, Kosrae did local home gardening and food recipes. There are more parents involved in the preventive care of their families through healthy lifestyles. The public health programs, including MCH has play a very important role in the increase parental knowledge on preventive health.

NOMs - CHILD HEALTH DOMAIN	2017	2018
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	91.2	68.9
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	82.6	30.6
NOM 19 - Percent of children in excellent or very good health	36.9%	38.5%

Challenges

Procurement of hearing screening supplies and shortage of staffs affected developmental screening in the dispensaries. The Sustainability of the LAUNCH Project program which also assists the child population domain in Pohnpei is uncertain at the moment. Dental preventive care and children needing immunization are still activities/services that need to be stabilize. Parents who had been drinking sakau and alcohol together leaving their children unsupervised thus prone to injuries such as fall, trauma, cut, etc.

Child Health - Application Year

CHILD Health - Plan for the Application Year:

The priority for this domain is improving the oral health of Children and reduce childhood injury.

Strategies:

To increase the number of school visited to educate and provide preventive measures especially on varnish and sealant was the NPM strategy for the priority under child domain.

There are several activities that the State MCH programs plan to implement in order to carry out the strategy and meet the goal of this population domain. Two States requested additional dental staff in their dental clinics to provide all the dental care for the children population. The MCH programs will collaborate with the States public safety on child prevention measures that would help decrease child injuries.

Another area that needs to improve on is the data base system that the programs are using to capture and track these measures on.

Domain and State Priority Needs (SPN)	NATIONAL PERFORMANCE MEASURE		Strategies	Evidence-based/-informed Strategy Measure (ESM)	ESM Num/Denom	STATE PERFORMANCE MEASURE	SPM Strategies
Child Health - NPM 13B							
<p><i>Priority 4. Improve oral health of children/ Priority 5. Reduce childhood injury</i></p>	<p>NPM 13: B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year</p>	<p>1. By end of 2020, percent of children age 1-5yo who have received fluoride varnish application at least once in 2019.</p>	<p>Increase the # of school visited to educate and provide preventive measures. (Varnish and sealant)</p>	<p>Percentage of elementary schools visited by dental program</p>	<p>Number of elementary schools visited by dental program.</p>	<p>SPM 5 - Incidence rate of 0-9 years old hospitalized for nonfatal injury/100,000</p>	<p>Do parental and community education campaign using visual aid, radio, television and posters in prominent areas in the schools and communities.</p>
		<p>2. By the end of December 2020, # of children from K-5 to 3rd graders receiving preventive dental services will be increase by at least 15%.</p>			<p>Number of Elementary Schools.</p>		

Following are several activities that are in place:

- Increase the number of dental staff in the dental clinic program – (Chuuk & Pohnpei)
- Do parental and community education campaign using visual aid, radio, television and posters in prominent areas in the schools and communities.
- Develop brochures and poster addressing topics on childhood injury and distributed to the community.
- Do parental training on childhood injury prevention with other stakeholders.
- Work with public safety and other affiliated agencies on children injury preventive measures

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS	Data Not Available or Not Reportable	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC	Data Not Available or Not Reportable	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS	Data Not Available or Not Reportable	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	14.9	NPM 10

National Performance Measures

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			35
Annual Indicator	0	0	0
Numerator	0	0	0
Denominator	100	100	100
Data Source	-- State --	-- State --	-- State --
Data Source Year	-- State	-- State	-- State
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	40.0	45.0	50.0	55.0	60.0	0.0

Evidence-Based or –Informed Strategy Measures

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	35.0	38.0	40.0	45.0	50.0	60.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Adolescent Health - Entry 1

Priority Need

Decrease incidence of teenage pregnancy and STI

NPM

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

Objectives

By the end of December 2019, teenage pregnancy rate will be decreased by 2% from the 2015 FSM baseline.

Strategies

Provide educational awareness on sexual health (teenage pregnancy) to adolescents ages 12-17 years old in all public schools on the main islands.

ESMs

Status

ESM 10.1 - Percent of Schools (7-12 graders) participating in Department of Health workshops to prevent STDs, drugs and alcohol use.	Inactive
ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

Decrease incidence of teenage pregnancy and STI

Objectives

Decreased teenage STI infections (Syphilis, GC, CT/HIV) to 10/1000 females age 15-19 years old.

Decrease teenage birth rate to 60/1000 females age 15-17.

Strategies

Provide educational awareness on sexual health (teenage pregnancy and STI) to adolescents ages 12-17 years old in all Public schools on the main islands.

Adolescent Health – Annual Report

Priority: 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, injuries, STI’s etc.).

NPM#10 - Percent of adolescents, ages 12 to 17, with a preventive medical visit in the past year was selected under the adolescent domain with a proxy indicator. In 2018, 48.4% of schools in the FSM with the target group (adolescents - ages 12 to 17) did received educational awareness on Reproductive health, Substance abuse and Physical health nutrition; an increase from the 2017 data which was 33%. The target for 2018 was 35 percent, and the FSM was short of 2 percent to reach the goal.

In 2018, FSM MCH program was able to reach out to more schools which showed about 15% increase from percentage of schools received awareness programs in 2017. All the 4 states in FSM reported collaboration with other public health programs on community reach outs to provide more awareness in schools and communities regarding the risk of alcohol and drug usage, the consequences of teenage pregnancy, STIs and injuries among this population. There was a strong collaboration between MCH and other Public Health programs (PREP, FP, STIs, NCD, Immunization, Cancer and BH & W) by providing supports/assistance in doing public awareness sharing of resources and manpower during outreach activities.

FSM MCH Program continued to partner with NGOs (Women’s group, Youth group and other stakeholders (CHC, SpEd, College of Micronesia) and communities by promoting healthy adolescent behaviors and reducing risk behaviors through (workshops, training, presentations, IEC materials) to the target population

MCH DOMAINS	2015	2016	2017	2018
ADOLESCENT HEALTH DOMAIN				
Promoting Healthy Behaviors and Reducing Risk Behaviors (alcohol, drugs, teen pregnancy, etc) Schools received educational awareness on healthy lifestyle	na	25%	33%	48.4%

All the schools that were reached in the reporting year did received educational awareness on teen pregnancy, STIs, alcohol, tobacco used and healthy lifestyles through collaborated public health programs. There were laws in place to protect alcohol and tobacco use in teenagers that was established in the State of Kosrae. Also, other laws were in place for passenger and driver safety (ksa).

NOMs - ADOLESCENT HEALTH DOMAIN	2017	2018
<i>NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</i>	0	17.3
<i>NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000</i>	0	17.5
<i>NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling</i>	9%	53.1%
<i>NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</i>	5.7%	4.1%
<i>NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza</i>	18.7%	25.7%
<i>NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</i>	9.3%	27.7%
<i>NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</i>	17.5%	57.3%
<i>NOM 24 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.</i>	24.4%	64.6%

In 2018, the rate of Adolescent motor vehicle mortality in FSM is increased by 17.3/100,000 from 0 in 2017 to 17.3 in 2018. This is due to less enforcement of driving safety rules, influence of alcohol use and with careless driver. Adolescent suicide rate in the FSM is also increased from 0 in 2017 to 17.5/100,000 in 2018 mainly due to family problem involvement and the influence of alcohol use as well.

During the reporting year the percentage of children with mental/behavior condition receiving treatment and counseling increased by 42%, from 9% in 2017 to 51.3% in 2018. This is because more parents are aware of the services available (treatment service in placed) in the states and the availability of the psychiatrist/ part time physicians and counselors to provide counseling and treatment services in BH & W Program. Screening tool use in the clinics, school, CHCs and outreaches to capture eligible clients and refer to BH&W to enroll in their system.

More awareness in the schools targeting healthy eating habits, exercise, and risks associated with obesity contributed to the decreased rate for Percent of children and adolescents who are overweight or obese decreased by 2% from 5.7% in 2017 to 4.1% in 2018. Some schools in the FSM are banning eating chunk food on campus, teaching and promoting home gardening to parents. Several stores in the FSM are displaying enticing food advertisements that are high in calories (fat, cholesterol, protein and etc) rather than food with low calories.

In 2018, the rate for this NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza increased by 7% from 18.7% in 2017 to 25.7% in 2018. Also, the rate for Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine increased by 10.4% from 17.3% in 2017 to 27.7% in 2018. This is due to the availability of HPV vaccines in the states, more awareness conducted in the schools and communities regarding the benefits of the HPV vaccines. The increases of percentages were due to the availability of the vaccines in the states, and more community outreach activities conducted in the states. Several Dispensaries on the main islands and CHCs are also providing flu vaccines at their sites.

In 2018, the rate for this NOM 22.4 increased by 40%, from 17.5% in 2017 to 57.3% in 2018. This is due to the availability of Tdap vaccine in the states, frequent visit to communities to update their vaccines. Immunization services are also provided at the CHC in FSM.

The rate of birth (per 1,000) for teenagers aged 15 through 17 years was increased by 40%, from 24.4% in 2017 to 64.6% in 2018; a significant increase in the history of FSM MCH program. This is mainly due to lifestyle changes, negligent of parents, domestic violence (sexual abuse) and several contributing factors to this issue. Teen pregnancy is increased from last reporting period despite efforts provided by the all public health programs staff and other affiliated agencies. Despite all the efforts on the awareness activities made on teen pregnancy in the communities, the States MCH program staff did mentioned that adopting western lifestyles (alcohol and other drug use) played a major role in teen pregnancy rate. Development of locally translated brochures, flyers and billboards was made to capture the attentions of youths who are in need of services on teen pregnancy and STDs.

Teenage pregnancy is a growing problem in the FSM. State MCH programs continues to network with all public health programs especially FP/Prep/HIV/STI/TB both in the clinic, schools and communities to motivate teenage for family planning services. The MCH program continue to support CHC, Women's groups, dispensaries and other public health programs that deals with the adolescent population to be accessible to the youth seeking services at their sites. The MCH, family planning and PREP programs staff provided hand in hand education awareness session on teen pregnancy prevention during school visits and community visits.

Chlamydia in teen women was also an outcome result of adolescent health. The percentage of women age 15-19 years old with Chlamydia cases was decreased by 7% from 23% in 2017 to 16.5% in 2018. This is because one state reported 0 Chlamydia positive in this age group (women aged 15-19 yrs). Another reason for the decrease was due to more awareness activities conducted in the schools and communities on STDs and STIs.

Challenges:

There is lack of youth friendly clinic services in the states. Each public health clinic is mainly for their health programs. Parents often left their youths alone to do their own stuffs and there were no routine activity for the kids to do, so instead of staying at home, the youths tend to roam the streets and involve in problems that leads to health issues like STI and teen pregnancy. Acceptance of teen pregnancy in the society is seemingly a norm nowadays.

Adolescent Health - Application Year

Adolescent Health - Plan for the Application Year:

Application Year Plan (FY19-FY20): This section presents objective, strategies and activities for FSM MCH priorities related to Adolescent Health.

Only one FSM MCH priority is addressed in the Adolescent Domain: Decrease incidence of teenage pregnancy and STI

Strategy: Provide educational awareness on Sexual Health (teenage pregnancy and STI) to adolescent ages 12 to 17 years old in all public schools on main islands.

Activity 1:

Planning and Preparation

- Collaborate with other public health programs (HIV/STI, PREP, Family Planning, etc...)
- Secure supplies and materials (IEC materials)
- Inform/meet with Director of DOE regarding the schools visits schedule and schedule meeting with the parents during PTA meeting

Activity 2:

Parents involvement

- To conduct a presentation on Teen pregnancy and STIs during PTA meeting
- Share strategies with the parents during PTA regarding the schools visits and get their consensus

Activity 3:

School visits

- Presentations on the consequences on STI and teen pregnancy and preventive services available
- Distribution of IEC materials (brochures, and pamphlets)

Domain and State Priority Needs (SPN)	NATIONAL PERFORMANCE MEASURE		Strategies	Evidence-based/-informed Strategy Measure (ESM)	ESM Num/Denom	STATE PERFORMANCE MEASURE	SPM Strategies
Adolescent Health - NPM 10							
<p><u>Priority 6.</u> Decrease incidence of teenage pregnancy and STI</p>	<p>NPM#10. Percent of adolescents, ages 12 to 17, with a preventive medical visit in the past year.</p>	<p>1. Decrease teenage birth rate to 60/1000 females age 15-17.</p>	<p>Provide educational awareness on sexual health (teenage pregnancy and STI) to adolescent ages 12-17 years old in all Public schools on main islands.</p>	<p><i>Percent of public middle and high schools visited to deliver pregnancy & STI prevention program.</i></p>	<p>Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program</p>		
		<p>2. Decrease teenage STI infections (infection with any of the following: Syphilis, GC, CT, HIV) to 10/1000 females age 15-19yo.</p>			<p>Number of public middle and high schools</p>		

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH	Data Not Available or Not Reportable	NPM 12

National Performance Measures

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives**

NPM 12 - Children with Special Health Care Needs

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	15.0	18.0	20.0	20.0	25.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			5	15
Annual Indicator	2.4	1.3	0	
Numerator	46	18	0	
Denominator	1,910	1,414	100	
Data Source	CSHCN program	CSHCN program	CSHCN program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	35.0	45.0	60.0	65.0	70.0

State Action Plan Table

State Action Plan Table (Federated States of Micronesia) - Children with Special Health Care Needs - Entry 1

Priority Need

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

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase the percentage of CSHCN youth who register for non-medical related services to 30%.

Strategies

Work collaboratively with DOE, IAC, DOHSA or other NGOs to strengthen the non-medical related services for CSHCN youth in each State.

ESMs	Status
ESM 12.1 - Percent of youths with Special Health Care Need (CSHCN) enrolled in the non-medical related programs to receive services.	Active
ESM 12.2 - Increase percent of children (1-17 years old) screened for developmental delay	Inactive

NOMs

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

Children with Special Health Care Needs - Annual Report

Children with Special Health Care Needs (CSHCN) – Annual Report

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

MCH DOMAINS	2015	2016	2017	2018
CHILDREN WITH SPECIAL HEALTH CARE NEEDS DOMAIN				
Provide Transitional Services for CSHCN youths (CSHCN youth employed)	na	2.4%	3%	1.3%

The target for 2018 was set at 8%. However, only 1.3% of adolescents with and without special health care needs received services necessary to make transitions to adult health care compared to 3% in 2017. This measure was actually a proxy to the NPM under the CSHCN domain. The FSM is tracking CSHCN youth who are employed.

- The 2017 data collection was based on all transitions i.e. within school levels, transitioning out of CSHCN program and inter-agency referrals; whereas in 2018, the data was focused only on those received employment before or after transitioning out of CSHCN program.
- Health Services department does not have employment program services that may help these adolescents transition into adult life.
- MCH program relies on transitional services in the department of education which does not exist in all the states.

According to Pohnpei MCH program, CSHCN youths have not reach transition stage yet. The 17 children that transition out last year (2017) were put on employment and continued working at convenient stores, gas stations, etc. Development Skill Program (ADSP) provides children with special health care need services/jobs when transition from High schools and college. Special Education provides CSHCN mother’s supports and services. Special education contact annual evaluation for mothers and their children to assess effectiveness of their services. Total number of children identified and enrolled in the CSHCN and Health services for follow up and treatment or management were 122 (RHD, Mental Health and Shriners and EHDI screening).

NOMs - CHILDREN with SPECIAL HEALTH CARE NEED (CSHCN) DOMAIN	2017	2018
<i>NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</i>	88.7%	97.1%

The percentage of CSHCN receiving care in a well-functioning system has increased by 8.4% from 2017 (88.7%) to 97.1% in 2018. The increase is due to:

1. Establishment of Community Health Centers (CHC) in Chuuk in 2018
2. Dispensaries and CHC in Pohnpei started servicing RHD clients
3. Dispensary strengthening pilot program activity in Pohnpei was then implemented as primary health care outreach activity in Chuuk
4. And improved accessibility of health care services to some dispensaries

Challenges

- Not all CSHCN children are in schools or enrolled at the Special Education program.

- There is no rehabilitation center where children can learn how to sew, cook, do gardening and build canoe, etc.
- No tracking data on transited CSHCN Clients
- Communities are not fully aware of the services available
- No such existing law regarding CSHCN youth becoming employee
- No Rehabilitation services where all this CSHCN youth that are not in school could register and get serve

Children with Special Health Care Needs - Application Year

Children with Special Health Care Needs (CSHCN) - Plan for the Application Year:

From current discussion on the Action Plan during the recent MCH Annual meeting conducted in June this year, it was decided that certain terms in the existing objective (Increase the percent of CSHCN youth who are enrolled in rehab services) and strategies should be changed; so that implementation of activities under this domain remain realistic for all the states within one year period. Reason for this change is because there are no existing rehab services and MCH was not able to reach a consensus on an alternative definition for 'rehabilitation services'.

Revised Objective: "Increase the percent of CSHCN youth who register for non-medical related services to 30%."

Strategy: Work collaboratively with DOE, IAC DOHSA or other NGO's to create or strengthen the non-medical related services for CSHCN youth.

1. Strengthen collaboration with DOE- SpEd and WD&ST (Workforce Development & Skills Trade)
2. Conduct public awareness to promote integration of CSHCN youth into community involvement
3. Identify interested entities and establish an MOU
4. Include in data:
 - DOE-SpEd physical therapy
 - Speech and Language therapy
 - Social Services (Autism Support group)
 - BHW Services (non-medical services) – counseling

Continue collaboration among programs, entities and community groups. Maintain collaborative efforts with families, CHC and dispensaries in all states. MCH programs will continue to strengthening awareness efforts in the communities on the availability and easy access of these health services to CSHCN youths. Work collaboratively with the NGOs, companies, churches, and other related services to help in serving this CSHCN youth.

Another suggestion from one of the MCH programs is to work collaboratively with DOE, DOHSA, NGO's and Interagency Committee/Stakeholders (IAC) to identify non-medical services and improve existing services to support programs to improve transition services to CSHCN youths.

Domain and State Priority Needs (SPN)	NATIONAL PERFORMANCE MEASURE		Strategies	Evidence-based/-informed Strategy Measure (ESM)	ESM Num/Denom	STATE PERFORMANCE MEASURE	SPM Strategies
Children with Special Health Care Needs - NPM 12							
<i>Priority 7. Provide a transitional services for youth identified as having Special Health Care Needs</i>	NPM 12: Percent of adolescents with or without special health care needs who received services necessary to make transitions to adult health care	Increase the percent of CSHCN youth who register for non-medical related services to 30%"	Work collaboratively with DOE, IAC DOHSA or other NGO's to strengthen the non-medical related services for CSHCN youth for each States.	<i>Percentage of CSHCN youth who ENROLL in the non-medical programs to receive the services.</i>	# of CSHCN youth who register for non-medical related services Total number of CSHCN youth in the registry		

Cross-Cutting/Systems Building

Cross-Cutting/Systems Building - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

III.F. Public Input

The FSM Title V - Maternal and Child Health Grant Application Package for 2020 will be out for public input on the FSM Public Information Office website for the months of July and August 2019. The information on the MCH Application 2020 Grant will also be posted for interest public review and comments at the public sites. FSM MCH Programs will do the final review of the grant application after the Grantees Block Grant Review in August 2019.



DEPARTMENT OF HEALTH AND SOCIAL AFFAIRS

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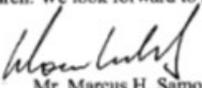
PUBLIC SERVICE ANNOUNCEMENT

This is to announce to the general public that FSM National Government Department of Health and Social Affairs wishes to announce to the General public that the Title V Maternal and Child Health (MCH) Block Grant Application for FY-2020 will be ready and available for public comment starting July 15 to August 30, 2019. Those interested to review this application and provide commend and feedback to this department of Health and Social Affairs, where the MCH Program in housed. You can send self-returned envelop to the following address or contact us by Phone or email.

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

Please specify where you want the package to be sent. Allow five business days from the day of message receipt for delivery.

Thank you for your support to ensure that we provide good and appropriate health care to our women, infants, mothers and children. We look forward to receiving your feedback.


Mr. Marcus H. Samo
Acting Secretary, FSM Department of Health and Social Affairs

III.G. Technical Assistance

III.G Technical Assistance

As with previous request in previous years, FSM MCH program continues to request for training in budget preparation and expenditure reporting for the National and State MCH program staff. The FSM MCH program also request training for data capacity in the development of existing database system that the MCH program at the national and state level are utilizing. FSM Title V program continues to request for TA Training similar to the TA held during April 2019 in Honolulu, Hawaii. FSM is suggesting TA to be provided based on hands-on and Peer-to-Peer sharing and learning.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Title V Medicaid.pdf](#)

V. Supporting Documents

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

Supporting Document #01 - [2020 Final FSM MCH ACTION PLAN.pdf](#)

Supporting Document #02 - [Final 2018 FSM MCH Data Matrix-app file.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [Existing FSM Organizational Chart.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Federated States of Micronesia

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

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

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 587,235		\$ 404,139	
A. Preventive and Primary Care for Children	\$ 176,485	(30.1%)	\$ 121,500	(30%)
B. Children with Special Health Care Needs	\$ 176,785	(30.1%)	\$ 121,500	(30%)
C. Title V Administrative Costs	\$ 58,602	(10%)	\$ 40,400	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 411,872		\$ 283,400	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 467,000		\$ 440,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 467,000		\$ 440,000	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 440,000				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 1,054,235		\$ 844,139	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 637,000		\$ 637,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 1,691,235		\$ 1,481,139	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 250,000	\$ 250,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 50,000	\$ 50,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 337,000	\$ 337,000

Form Notes for Form 2:

As of Today, September 25, 2019, the total MCH expenditures was \$404,139.00 in FY-2018. The remaining balance will be spend not later than September 30th and during this Liquidation period.

Field Level Notes for Form 2:

1.	Field Name:	1.FEDERAL ALLOCATION
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	As of September 25, 2019, the total MCH Program Expenditure was \$404,139.in FY-2018. The remaining balance will be spend not later than September 30th and during the Liquidation period.
2.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	This amount of \$404,139 is the total MCH Expenditures in FY-2018.
3.	Field Name:	Federal Allocation, B. Children with Special Health Care Needs:
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	The total expenditure that was reported was based on the approved Notice of Grant Award in FY-18.
4.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	This total expenditures was based on the approve Notice of Grant Award in FY-2018.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Federated States of Micronesia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 90,752	\$ 60,139
2. Infants < 1 year	\$ 79,982	\$ 60,600
3. Children 1 through 21 Years	\$ 170,735	\$ 121,500
4. CSHCN	\$ 170,785	\$ 121,500
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 512,254	\$ 363,739

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 132,000	\$ 86,500
2. Infants < 1 year	\$ 87,000	\$ 121,040
3. Children 1 through 21 Years	\$ 89,000	\$ 132,400
4. CSHCN	\$ 132,000	\$ 100,060
5. All Others	\$ 0	\$ 0
Non-Federal Total of Individuals Served	\$ 440,000	\$ 440,000
Federal State MCH Block Grant Partnership Total	\$ 952,254	\$ 803,739

Form Notes for Form 3a:

As of July 9, 2019, the total amount of \$300,019 is the total expenditures that was reported during this grant submission. We still have the remaining balance that will be spend before September 30, 2019.

Field Level Notes for Form 3a:

1.	Field Name:	IA. Federal MCH Block Grant, Federal Total of Individuals Served
	Fiscal Year:	2018
	Column Name:	Annual Report Expended

Field Note:

As of July 10, 2019, the total amount of \$300,018 is the total expenditures that was reported during this grant submission. The remaining balance will be spend before September 30, 2019.

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Federated States of Micronesia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 467,370	\$ 404,139
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 186,500	\$ 131,639
B. Preventive and Primary Care Services for Children	\$ 110,085	\$ 151,000
C. Services for CSHCN	\$ 170,785	\$ 121,500
2. Enabling Services	\$ 48,659	\$ 0
3. Public Health Services and Systems	\$ 53,035	\$ 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		\$ 63,772
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 84,949
Dental Care (Does Not Include Orthodontic Services)		\$ 85,000
Durable Medical Equipment and Supplies		\$ 100,298
Laboratory Services		\$ 70,120
Direct Services Line 4 Expended Total		\$ 404,139
Federal Total	\$ 569,064	\$ 404,139

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 283,425	\$ 440,000
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 85,000	\$ 125,100
B. Preventive and Primary Care Services for Children	\$ 66,425	\$ 135,211
C. Services for CSHCN	\$ 132,000	\$ 179,689
2. Enabling Services	\$ 85,075	\$ 0
3. Public Health Services and Systems	\$ 71,500	\$ 0
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 80,500
Physician/Office Services		\$ 72,000
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 65,305
Dental Care (Does Not Include Orthodontic Services)		\$ 149,195
Durable Medical Equipment and Supplies		\$ 25,000
Laboratory Services		\$ 48,000
Direct Services Line 4 Expended Total		\$ 440,000
Non-Federal Total	\$ 440,000	\$ 440,000

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: Federated States of Micronesia

Total Births by Occurrence: 1,890

Data Source Year: 2018

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	1,589 (84.1%)	0	0	0

Program Name(s)
Hearing Loss

2. Other Newborn Screening Tests

None

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
MCH Program Rheumatic Heart Disease	3,278	150	150	150

4. Long-Term Follow-Up

The FSM does not have enough information on the long-term follow up on infant referral or treatment. The practice for the state depends mainly on the healthcare coverage that an infant has or if the family could afford the referral process and payments that should take place outside of the FSM. Yet, the program along with the local doctors should monitor and provide support to the infant and his/her family.

Form Notes for Form 4:

The only newborn screening in the FSM is hearing screening. No other newborn screening is performed at the OB wards.

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2018
	Column Name:	Total Births by Occurrence Notes
	Field Note:	ref - 2018 MCH Data matrix
2.	Field Name:	Data Source Year
	Fiscal Year:	2018
	Column Name:	Data Source Year Notes
	Field Note:	MCH DM data collection year
3.	Field Name:	MCH Program Rheumatic Heart Disease - Receiving At Least One Screen
	Fiscal Year:	2018
	Column Name:	Older Children & Women
	Field Note:	Number of children and adolescents ages 5-21 years old screened for Rheumatic heart disease

Data Alerts: None

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

State: Federated States of Micronesia

Annual Report Year 2018

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

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,062	0.0	0.0	0.0	100.0	0.0
2. Infants < 1 Year of Age	1,989	0.0	0.0	0.0	100.0	0.0
3. Children 1 through 21 Years of Age	20,471	0.0	0.0	0.0	100.0	0.0
3a. Children with Special Health Care Needs	1,838	0.0	0.0	0.0	100.0	0.0
4. Others	7,074	0.0	0.0	0.0	100.0	0.0
Total	31,596					

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

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	2,079	No	2,350	98	2,303	2,062
2. Infants < 1 Year of Age	2,043	No	2,250	100	2,250	1,989
3. Children 1 through 21 Years of Age	44,450	Yes	44,450	60	26,670	20,471
3a. Children with Special Health Care Needs	Not Available	Yes	Not Available	50		1,838
4. Others	57,703	Yes	57,703	30	17,311	7,074

Form Notes for Form 5:

Under form 5a 100% for (E) none column under Primary source of coverage denoted that all coverage are covered by Title V funding and no other source of funding indicated.

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2018
	Field Note:	2018 MCH Data Matrix
2.	Field Name:	Infants Less Than One Year Total Served
	Fiscal Year:	2018
	Field Note:	2018 MCH Data Matrix
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	2018 MCH Data Matrix
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	2018 MCH Data Matrix
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	Women who received MCH services with some kind of preventive medical visit in the past year.

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2018
	Field Note:	Pregnant women from the Outer islands who gave birth on the OI were not counted.
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2018
	Field Note:	Every infant have received at least one service from the MCH program
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2018
	Field Note:	According to FSM population projection trend in 2018, the targeted age 1-21 is 41, 651.
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2018
	Field Note:	There is no population survey yet on this population domain. Figures are estimates.
5.	Field Name:	Others
	Fiscal Year:	2018
	Field Note:	There were no services provided to other older age groups by the MCH program. Figures are estimated on anemia cases

Data Alerts: None

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

State: Federated States of Micronesia

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	1,890	0	0	0	0	0	1,890	0	0
Title V Served	1,589	0	0	0	0	0	1,589	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0
2. Total Infants in State	1,989	0	0	0	0	0	1,989	0	0
Title V Served	1,772	0	0	0	0	0	1,772	0	0
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Title V Served
	Fiscal Year:	2018
	Column Name:	Total
	Field Note:	hearing screening prior to hospital discharge

2.	Field Name:	2. Title V Served
	Fiscal Year:	2018
	Column Name:	Total
	Field Note:	hearing and anemia screening

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

State: Federated States of Micronesia

Toll-Free numbers are not available to all jurisdictions.

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number		
2. State MCH Toll-Free "Hotline" Name		
3. Name of Contact Person for State MCH "Hotline"		
4. Contact Person's Telephone Number		
5. Number of Calls Received on the State MCH "Hotline"		

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	None	
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	Under construction	
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites	Not applicable	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Federated States of Micronesia

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

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

3. State Family or Youth Leader (Optional)

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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs
State: Federated States of Micronesia

Application Year 2020

No.	Priority Need
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, hearing and anemia screening of the infant and promoting breastfeeding.
3.	Improve child health through providing vaccinations and screening for developmental delays
4.	Provide a transitional services for youth identified as having Special Health Care Needs
5.	Improve oral health of children
6.	Decrease incidence of teenage pregnancy and STI
7.	Reduce childhood injury

Form 9 State Priorities-Needs Assessment Year - 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 10
National Outcome Measures (NOMs)

State: Federated States of Micronesia

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

Although this measure is listed under the NOMs, FSM still want to continue to collect this as a SPM and will start to report on this SPM in 2019.

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

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

State Provided Data	
	2018
Annual Indicator	30.6
Numerator	579
Denominator	1,890
Data Source	MCH Prenatal Clinic and Vital Statistics
Data Source Year	2018

NOM 1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	18.0
Numerator	3
Denominator	1,664
Data Source	Vital Statistics
Data Source Year	2018

NOM 2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	211.6
Numerator	4
Denominator	1,890
Data Source	Vital Statistics
Data Source Year	2018

NOM 3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	7.8
Numerator	147
Denominator	1,890
Data Source	Birth Certificate and Vital Statistics
Data Source Year	2018

NOM 4 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	3.2
Numerator	60
Denominator	1,890
Data Source	Birth and Vital Statistics
Data Source Year	2018

NOM 5 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	10.1
Numerator	191
Denominator	1,890
Data Source	Birth and Vital Statistics
Data Source Year	2018

NOM 6 - Notes:

None

Data Alerts: None

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

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

NOM 7 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	18.2
Numerator	35
Denominator	1,925
Data Source	Vital Statistics
Data Source Year	2018

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	26.7		67	
2016	27.4		68	
2015	28.2		69	
2014	29.0		71	
2013	29.9		73	
2012	30.8		75	
2011	31.7		78	
2010	32.6		81	
2009	33.4		84	

Legends:

- 🚫 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	20.6
Numerator	39
Denominator	1,890
Data Source	Vital Statistics
Data Source Year	2018

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	16.5		42	
2016	17.2		43	
2015	17.7		44	
2014	18.4		45	
2013	19.0		46	
2012	19.5		48	
2011	19.9		49	
2010	20.4		50	
2009	21.0		53	

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2018
Annual Indicator	16.9
Numerator	32
Denominator	1,890
Data Source	Vital Statistics
Data Source Year	2018

NOM 9.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	3.2
Numerator	6
Denominator	1,890
Data Source	Vital Statistics
Data Source Year	2018

NOM 9.3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	687.8
Numerator	13
Denominator	1,890
Data Source	Vital Statistics
Data Source Year	2018

NOM 9.4 - Notes:

None

Data Alerts: None

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

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

NOM 9.5 - Notes:

This measure is not tracked.

Data Alerts:

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

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

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

NOM 10 - Notes:

There is no service provided for this measure

Data Alerts:

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

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

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

NOM 11 - Notes:

FSM does not track or have any data for this measure

Data Alerts:

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

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

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

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	15.1
Numerator	5,834
Denominator	38,608
Data Source	Dental/Oral Health Program and Census
Data Source Year	2018

NOM 14 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	68.9
Numerator	14
Denominator	20,330
Data Source	Vital Statistics and Census
Data Source Year	2018

NOM 15 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	30.6
Numerator	7
Denominator	22,841
Data Source	Vital Statistics and Census
Data Source Year	2018

NOM 16.1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	17.3
Numerator	2
Denominator	11,541
Data Source	Vital Statistics and Census
Data Source Year	2018

NOM 16.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	17.3
Numerator	2
Denominator	11,541
Data Source	Vital Statistics and Census
Data Source Year	2018

NOM 16.3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	4.7
Numerator	1,879
Denominator	39,927
Data Source	CSHCN program and Census
Data Source Year	2018

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	4.7
Numerator	1,884
Denominator	39,927
Data Source	CSHCN Program and Census
Data Source Year	2018

NOM 17.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.1
Numerator	26
Denominator	30,641
Data Source	CSHCN Program and Census
Data Source Year	2018

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	0.1
Numerator	17
Denominator	30,641
Data Source	CSHCN and Census
Data Source Year	2018

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	3.4
Numerator	34
Denominator	989
Data Source	CSHCN program and Mental health program
Data Source Year	2018

NOM 18 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	38.5
Numerator	15,479
Denominator	40,235
Data Source	MCH program and Census
Data Source Year	2018

NOM 19 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	4.1
Numerator	472
Denominator	11,510
Data Source	Well baby Clinic and MCH Program
Data Source Year	2018

NOM 20 - Notes:

FSM did not have data on (WIC, NSCH and YRBSS) measure for this particular indicator. There were proxy data on services provided at the MCH programs.

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	73.8
Numerator	29,710
Denominator	40,235
Data Source	MiCare Health Insurance and Census
Data Source Year	2018

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

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

State Provided Data	
	2018
Annual Indicator	86.4
Numerator	4,124
Denominator	4,772
Data Source	Immunization Program and WebIZ
Data Source Year	2018

NOM 22.1 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	25.7
Numerator	10,601
Denominator	41,293
Data Source	Immunization and Census
Data Source Year	2018

NOM 22.2 - Notes:

None

Data Alerts: None

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

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

State Provided Data	
	2018
Annual Indicator	27.7
Numerator	2,136
Denominator	7,723
Data Source	Immunization and Census
Data Source Year	2018

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	57.3
Numerator	8,165
Denominator	14,255
Data Source	Immunization and Census
Data Source Year	2018

NOM 22.4 - Notes:

None

Data Alerts: None

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

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

NOM 22.5 - Notes:

FSM does not have meningococcal vaccine.

Data Alerts:

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

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

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

NOM 24 - Notes:

FSM does not track this measure but will look into the next reporting year to start tracking this measure.

Data Alerts:

1.	Data has not been entered for NOM 24. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
----	--

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

NOM 25 - Notes:

FSM does not track this measure.

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Federated States of Micronesia

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

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

State Provided Data			
	2016	2017	2018
Annual Objective	20	30	78
Annual Indicator	26	76.3	73.8
Numerator	1,320	9,582	7,074
Denominator	5,080	12,556	9,589
Data Source	MCH program	MCH program	MCH Program
Data Source Year	2016	2017	2018
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	85.0	87.0	90.0	95.0	97.0

Field Level Notes for Form 10 NPMs:

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

NPM 4A - Percent of infants who are ever breastfed

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	85.0	90.0	95.0	100.0	100.0	100.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	No data collected for this measure in 2016.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	This measure is not selected for 2017 reporting.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	Measure not selected for 2018 reporting.

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

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	78.0	80.0	83.0	85.0	88.0	90.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data			
	2016	2017	2018
Annual Objective			35
Annual Indicator	0	0	0
Numerator	0	0	0
Denominator	100	100	100
Data Source	-- State --	-- State --	-- State --
Data Source Year	-- State	-- State	-- State
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	40.0	45.0	50.0	55.0	60.0	0.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	There are no FSM population-based data for this NPM.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	The preventive medical visit data was not collected in 2017. FSM did collect an alternate indicator for this NPM - Increase education awareness on Reproductive health, Substance abuse and Physical healthh nutrition in 25% schools. The numerator is # of schools received educational awareness on healthy lifestyle, and denominator is # of Schools (7-12 grades) in State.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	FSM discontinued to report on this NPM due to lack of data. Moreover, the proxy for this NPM is ESM 10.2

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

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

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	10.0	15.0	18.0	20.0	20.0	25.0

Field Level Notes for Form 10 NPMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
FSM use percentage of CSHCN youths employed as a proxy for this NPM.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
This indicator was tracked based on questions asked during services for CSHCN families whom their kids received transitional service from the CSHCN programs.
- Field Name:** 2018

Column Name: State Provided Data

Field Note:
This indicator was tracked based on the proxy question asked during CSHCN services on transitional service from the CSHCN programs. In 2018, not many clients were able to attend a rehabilitation service.

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health
Federally available Data (FAD) for this measure is not available/reportable.

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	27.0	35.0	40.0	50.0	60.0

Field Level Notes for Form 10 NPMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
Data was collected for NPM 13B (children ages 1-9 yrs. old)
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Oral health for children K5- 3rd graders receiving dental awareness and dental services (varnish and sealants) is a proxy for this NPM.
- Field Name:** 2018

Column Name: State Provided Data

Field Note:
Dental for children 1 to 5 years old and children in K5 to 3rd graders receiving dental awareness and dental services (varnish and sealants) is a proxy for this NPM.

Form 10
State Performance Measures (SPMs)
State: Federated States of Micronesia

SPM 1 - Percent of women (15-44 years old) screen for anemia for the past year

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			13	75
Annual Indicator	15.1	69.5	19.4	
Numerator	615	5,272	4,384	
Denominator	4,064	7,584	22,610	
Data Source	MCH program	MCH program	MCH program and Census	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	22.0	27.0	33.0	38.0	43.0	50.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

This measure was already tracked in the ESMs; therefore, this SPM will be changed in 2017/2019 application to the percent of pregnant women aged 15 through 44 years diagnosed with Syphilis who are treated with penicillin.

SPM 4 - Percent of infants screened for hearing

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		83	76	
Annual Indicator	79.1	73	79.9	
Numerator	1,599	1,512	1,589	
Denominator	2,021	2,072	1,989	
Data Source	EHDI program and Vital stats	EHDI program and Vital stats	EHDI program and Vital stats	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	85.0	90.0	95.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	500.0	400.0	300.0	200.0	100.0	50.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	60.0	70.0	80.0	90.0	95.0

Field Level Notes for Form 10 SPMs:

None

SPM 8 - Percent of women 21-65 years old who have had VIA/PAP screening performed within the past year

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	20.0	25.0	30.0	35.0	50.0	

Field Level Notes for Form 10 SPMs:

None

**Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Federated States of Micronesia

ESM 1.1 - Percentage of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			28	30
Annual Indicator	26	21.6	25.3	
Numerator	1,320	1,637	5,728	
Denominator	5,080	7,584	22,610	
Data Source	MCH program	MCH program	MCH program and Census	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	32.0	35.0	38.0	40.0	45.0	50.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Screenings of Pap/VIA and Anemia were merged for this indicator and will start to be tracked from 2019 and on.

ESM 4.2 - Percent of six months old exclusively breastfed.

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		73	65	
Annual Indicator	69.7	59.4	70.7	
Numerator	1,359	1,155	1,336	
Denominator	1,950	1,944	1,890	
Data Source	MCH program and Birth Certificate	MCH program and Birth Certificate	MCH program and Birth Certificate	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	80.0	85.0	90.0	92.0	95.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	35.0	38.0	40.0	45.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective		5	15	
Annual Indicator	2.4	1.3	0	
Numerator	46	18	0	
Denominator	1,910	1,414	100	
Data Source	CSHCN program	CSHCN program	CSHCN program	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	35.0	45.0	60.0	65.0	70.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Kosrae State did not have any transitioning program for their CSHCN population.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data was reported on old indicator: Percentage of CSHCN youths employed. FSM will start to report on this indicator starting in 2019.
3.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note:	This measure is new and will be track starting this reporting year.

ESM 13.2.1 - Percentage of elementary schools visited by dental program

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			15	50
Annual Indicator	9.4	46.9	0	
Numerator	1,861	4,701	0	
Denominator	19,766	10,020	100	
Data Source	Dental program and Census	Dental program and Census	Dental program and Census	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Provisional	Provisional	Provisional	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	40.0	50.0	60.0	70.0	80.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2018
	Column Name:	State Provided Data

Field Note:

This measure will be tracked starting this reporting year.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Federated States of Micronesia

SPM 1 - Percent of women (15-44 years old) screen for anemia for the past year
Population Domain(s) – Women/Maternal Health

Measure Status:	Active									
Goal:	To screen all women for Anemia at the public health, hospital, dispensaries, schools and CHC.									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>Total number of women (15-44 years old) screen for Anemia.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of women (15-44 years old) in the state</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Total number of women (15-44 years old) screen for Anemia.	Denominator:	Total number of women (15-44 years old) in the state	Unit Type:	Percentage	Unit Number:	100
Numerator:	Total number of women (15-44 years old) screen for Anemia.									
Denominator:	Total number of women (15-44 years old) in the state									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Public Health Records									
Significance:	Anemia is a problem for pregnant women in the FSM. It is better to track and treat anemia before a woman gets pregnant.FSM decides to detect and treat anemia early before pregnancy to avoid complication of anemia during pregnancy.									

SPM 4 - Percent of infants screened for hearing
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	Increase percent of newborns who had hearing screening								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children screened for hearing</td> </tr> <tr> <td>Denominator:</td> <td>Number of occurent births during the reporting year</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of children screened for hearing	Denominator:	Number of occurent births during the reporting year	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of children screened for hearing								
Denominator:	Number of occurent births during the reporting year								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	FSM HER-FamilyTrac System; Birth records								
Significance:	Hearing health is important as it also determines a child's future educational attainment.								

SPM 6 - Prevalence rate of 0-9 years old hospitalized for nonfatal injury/100,000
Population Domain(s) – Child Health

Measure Status:	Active								
Goal:	Reduce rate of hospitalization for non-fatal injury								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of 0-9 years old injured</td> </tr> <tr> <td>Denominator:</td> <td>Number of 0-9 years old in the state</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> </table>	Numerator:	Number of 0-9 years old injured	Denominator:	Number of 0-9 years old in the state	Unit Type:	Rate	Unit Number:	100,000
Numerator:	Number of 0-9 years old injured								
Denominator:	Number of 0-9 years old in the state								
Unit Type:	Rate								
Unit Number:	100,000								
Data Sources and Data Issues:	Hospital and Public Safety								
Significance:	According to WHO, Injuries—resulting from traffic collisions, drowning, poisoning, falls or burns - and violence - from assault , self-inflicted violence or acts of war—kill more than five million people worldwide annually and cause harm to millions more. They account for 9% of global mortality, and are a threat to health in every country of the world. For every death, it is estimated that there are dozens of hospitalizations, hundreds of emergency department visits and thousands of doctors' appointments								

SPM 7 - Percentage of pregnant women with a first-trimester prenatal visit
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active								
Goal:	To improve perinatal outcomes during the early prenatal care visit								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of live births with reported first prenatal visit during the first trimester (before 13 weeks = gestation) in the calendar year.</td> </tr> <tr> <td>Denominator:</td> <td>Total number of live births in the State in the calendar year.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of live births with reported first prenatal visit during the first trimester (before 13 weeks = gestation) in the calendar year.	Denominator:	Total number of live births in the State in the calendar year.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of live births with reported first prenatal visit during the first trimester (before 13 weeks = gestation) in the calendar year.								
Denominator:	Total number of live births in the State in the calendar year.								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	Reduce the rate of fetal deaths								
Data Sources and Data Issues:	FSM MCH programs								
Significance:	Visits during the first trimester improve the development of the baby and the pregnancy.								

SPM 8 - Percent of women 21-65 years old who have had VIA/PAP screening performed within the past year
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	To screen all women for cervical cancer in Public health, Hospital, dispensaries, CHC and schools								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Total number of women ages 21-65 years old who have had cervical cancer screening</td> </tr> <tr> <td>Denominator:</td> <td>Total number of women ages 21-65 years old in the State</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Total number of women ages 21-65 years old who have had cervical cancer screening	Denominator:	Total number of women ages 21-65 years old in the State	Unit Type:	Percentage	Unit Number:	100
Numerator:	Total number of women ages 21-65 years old who have had cervical cancer screening								
Denominator:	Total number of women ages 21-65 years old in the State								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	FSM MCH and Cancer programs								
Significance:	Cervical cancer is one of the highest mortality rates among women in the FSM.								

Form 10
State Outcome Measure (SOM) Detail Sheets
State: Federated States of Micronesia

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Federated States of Micronesia

ESM 1.1 - Percentage of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening

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

Measure Status:	Active									
Goal:	To increase awareness workshops to women ages 15-65 in the communities on cervical cancer and anemia screening.									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 30%;">Numerator:</td> <td>Number of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening</td> </tr> <tr> <td>Denominator:</td> <td>Total number of women (15-65 years old) in the state</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening	Denominator:	Total number of women (15-65 years old) in the state	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of women (15-65 years old) received awareness workshop on anemia and cervical cancer screening									
Denominator:	Total number of women (15-65 years old) in the state									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Public Health Data, Census									
Significance:	Cervical cancer is one of the leading causes of death for women in the FSM. The MCH program wishes to prioritize cervical and anemia screening by increasing Pap smear and VIA screening during a women's preventive visit so cervical cancer can be detected early and treated.									

ESM 4.2 - Percent of six months old exclusively breastfed.

NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active	
Goal:	Increase percent of infants who are ever breastfed and breastfed up to six months	
Definition:	Numerator:	Number of babies having 6 months old well baby visit in MCH clinics in 2019 noted to be exclusively breastfed
	Denominator:	Number of babies having 6 months old well baby visit in MCH clinics in 2019
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	MCH Program Data and Vital Statistics	
Significance:	<p>Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post-natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.</p>	

ESM 10.2 - Percent of public middle and high schools visited to deliver pregnancy & STI prevention program
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active								
Goal:	Increase educational awareness on sexual health (teen pregnancy and STI) to adolescents ages 12-17 years old in public schools on main islands.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program</td> </tr> <tr> <td>Denominator:</td> <td>Number of public middle and high schools.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program	Denominator:	Number of public middle and high schools.	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of public middle and high schools visited with completed delivery of pregnancy & STI prevention program								
Denominator:	Number of public middle and high schools.								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	MCH and Department of Education								
Significance:	Women who become pregnant during their teens are at increased risk for medical complications, such as premature labor, and social consequences.								

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

NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active									
ESM Subgroup(s):	CSHCN									
Goal:	Collaborate with Department of Education (SPED), IAC Department of Health and other NGOs to strengthen the services for CSHCN youths in each state.									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of CSHCN youth registered for non-medical related services</td> </tr> <tr> <td>Denominator:</td> <td>Total number of CSHCN youth in the registry</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of CSHCN youth registered for non-medical related services	Denominator:	Total number of CSHCN youth in the registry	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of CSHCN youth registered for non-medical related services									
Denominator:	Total number of CSHCN youth in the registry									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	CSHCN Data									
Significance:	In the FSM, the CSHCN Inter-agency Council has member representative from the private sector, people who run major businesses and hardware stores in the country. By involving business representatives on the council, it is our hope that the business community will learn more about the children and youths with special health care needs and the transition program and therefore provide them with employment opportunities.									

ESM 13.2.1 - Percentage of elementary schools visited by dental program

NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active								
ESM Subgroup(s):	Children 0 through 5, Children 6 through 11								
Goal:	Increase the number of schools visited to educate and provide preventive measures (varnish & sealant).								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of elementary schools visited by dental program</td> </tr> <tr> <td>Denominator:</td> <td>Number of elementary schools</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of elementary schools visited by dental program	Denominator:	Number of elementary schools	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of elementary schools visited by dental program								
Denominator:	Number of elementary schools								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Dental Health data and School record								
Significance:	<p>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care. State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</p>								

**Form 11
Other State Data**

State: Federated States of Micronesia

The Form 11 data are available for review via the link below.

[Form 11 Data](#)