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**FEDERATED STATES OF MICRONESIA
MCH PROGRAM NEEDS ASSESSMENT FOR 2010-2015**

A. NEEDS ASSESSMENT PROCESS

1. Background

The FSM Department of Health and Social Affairs (DHS) conducted an assessment of the MCH Program in the States of Yap, Chuuk, Kosrae, and Pohnpei from April 19-May 20, 2010. The exact dates for the assessment in each of the states are as follows:

- Yap State: April 19-20, 2010
- Chuuk State: April 22-23, 2010
- Kosrae State: April 27-28, 2010
- Pohnpei State: May 13-14, 2010
- *Final Presentation: June 7-12, 2010 (conducted in Chuuk)*

After the entire a workshop was held in each of the FSM states, the final get together was in June 7-12, 2010 where everything from data analysis, performance and target setting, discussion on state vs National performance measures, including budget allocation, was discussed.

What follows throughout this needs assessment is documentation of the process and outcome of the needs assessment for the next five years, 2010-2015.

2. Purpose

HRSA required that each State Agency for the MCH Program conduct a five-year needs assessment as part of the Title V Program Submission. In response to this requirement and in order to better implement the MCH Program, the FSM DHS chose to conduct an approach that will not only determine the strengths and weaknesses of the MCH Program in the FSM, but also to assess the environment in which the MCH Program is implemented. Therefore, FSM HSA conducted the needs assessment to better understand the factors, circumstances and situations that can contribute to the success, or lack off, of providing health care to the women, infants and children.

3. Rationale for Approach

FSM HAS chose to conduct the needs assessment using existing staff from the FSM National Government and the State Government level. However, unlike the past, the National Government staff visited each of the FSM states and conducted the needs assessment during the dates indicated above.

The MCH Program staff from the States arranged the schedule of the assessment and invited the appropriate participants for the workshop. Inasmuch as possible, participants of the workshop represented concerned agencies of the government, the private sector, parents, and policy makers.

Choosing this approach where existing staff conduct the needs assessment is built on the philosophy to build capacity and confidence of staff from both the National and State level. In addition, this approach developed a “core” cadre of professionals who can conduct this kind of assessment for the MCH Program or any other public health program in the future.

4. Planning and Preparation for Conducting Needs Assessment

4.1 Review of Past Experience

FSM already have some experience in conducting needs assessment. The five years needs assessment for years 2005-2010 was conducted by the staff of the MCH National and State programs which formed the direction and priorities for implementation activities for the years 2005-2010. Therefore, the FSM HAS felt there was enough institutional and program staff experience already in place to conduct the needs assessment by ourselves.

4.2 Selecting Appropriate Methodology

A needs assessment tool that is easy to understand and appropriate for the FSM setting was the prime motivator in selecting a manual to use. A literature search of published articles, references and manuals lead to program staff to a starting point. However, after reviewing the result of the literature search it was felt necessary to narrow the scope to materials endorsed by MCHB, HRSA. ***The Capacity Assessment for State Title V (CAST-5) Preliminary Edition March 2001¹*** was reviewed and selected as the main tool or manual for this assessment coupled with the ***HRSA MCH Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report (OMB No. 0915-0172)²***. The reason for selecting the CAST-5 tool was because of Title V State Agency’s desire to also review the domains of the health delivery systems that can influence the MCH Program ability to meet the needs of women, infants and children.

It is the belief of the FSM HAS that the “environment” in which the MCH Program operates largely determines the success of the program. In that vein, what the health system is expected to provide for its population can also affect any public health program’s ability to meet its goal and objectives. For that reason, focusing on the 10 essential public health services was a logical approach.

4.3 Using the Ten (10) Essential Public Health Services as Basis for Needs Assessment

Although a review of the 10 Essential Public Health Services (EPHS) would probably need to take longer than the three days spent in each of the FSM states for the entire needs assessment process, it was felt necessary to at least look at how the 10 EPHS, as they relate to MCH

FSM MCH Program – Shaping the Next Generation

Programs, were implemented (see chart below). Management felt necessary to at least have the MCH Program staff review the programs’ capacity in meeting the 10 EPHS. This was done by having the program staff complete the core questions and the process indicators (see **Attachment 1-10**) for each EPHS.

Figure 1. The 10 Essential Public Health Services

Application of 10 EPHS in MCH - 1		Application of 10 EPHS in MCH - 2	
10 EPHS – Overall	10 EPHS – MCH Focus	10 EPHS – Overall	10 EPHS – MCH Focus
1. Monitor health status to identify and solve community health problems	1. Assess and monitor maternal child health status to identify and address problems	6. Enforce laws and regulations that protect health and ensure safety	6. Promote and enforce legal requirements that protect the health and safety of women, children and youth and ensure public accountability for their wellbeing
2. Diagnose and investigate health problems and health hazards in the community	2. Diagnose and investigate health problems and hazards affecting women, children and youth	7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable	7. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of health care
3. Inform, educate, and empower people about health issues	3. Inform and educate the public and families about maternal child health issues	8. Assure a competent public and personal health care workforce	8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal child health needs
4. Mobilize community partnerships to identify and solve health problems	4. Mobilize community partnerships between policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems	9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services	9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal child services
5. Develop policies and plans that support individual and community health efforts	5. Provide leadership for priority setting, planning, and policy development to support community efforts	10. Research for new insights and innovative solutions to health problems	10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems

Thursday, June 10, 2010 Chuuk 2011-2015 MCH Needs and Capacity Assessment 8 Thursday, June 10, 2010 2011-2015 MCH Needs and Capacity Assessment 9

Having an indication as to where each of the MCH Programs in the states fall on the continuum of services would not only allow management to articulate needs, but would also allow the opportunity to design work plans to meet those needs.

4.4 Configuring Needs Assessment Team

The following state and non-state agencies were represented in the needs assessment, which essentially made up the Needs Assessment Team. It should be mentioned that only the core staff of the Assessment Team from the FSM National Government actually travelled to the FSM states to conduct the onsite needs assessment. When onsite, the various agencies who had stakes in the MCH Program, participated in the discussions and consultations.

- Management of the Title V Agency (FSM HSA)
- FSM National MCH Program (including financial specialists)
- FSM CSHCN Physician
- State Department of Health Services Management
- State MCH Programs
- State Physicians/Pediatricians
- State CSHCN Program
- State SSDI Data Clerks
- State Special Education Programs
- State Early Childhood Education Programs
- State Substance Abuse and Mental Health Programs

- State Parents of CSHCN Association
- State Women Association Council
- State Insurance Program
- State Public Health Chiefs
- State Law Enforcement Agency

For specific names of individuals participated in the assessment and agencies represented, refer to the (see **Attachments 11-14**).

4.5 Roles of Individual Needs Assessment Team Members

For the core members of the Assessment Team from the FSM National level, the roles included management of the FSM National Department of H& Social Affairs, FSM MCH Program, pediatrician, data and fiscal management.

The roles the members from the State levels fulfilled included mainly program management and partner agencies. The tasks assigned to each of the core members of the assessment team was such that it was based on their skills and training. The core team comprised of the Assistant Secretary of Health, National MCH Coordinator, National CSHCN Physician and National Family Planning Program Coordinator. The National MCH Coordinator was responsible for the overall coordination and conduct of needs assessment exercise, ensuring that all data requirements are available, and program requirements are met. The CSHCN Physician was responsible for ensuring that all clinical services are carefully assessed and the Assistant Secretary was responsible in leading the needs assessment process and analysis of the data. The Assistant Secretary has extensive knowledge in data analysis through the many training programs that he had attended before. The national family planning program coordinator was responsible for the logistical arrangements and ensuring that all stakeholders are present as well as taking notes of the deliberations. The core team members were involved in the actual conduct of the 2005 needs assessment. The process was also participatory because opinions and views from the participants on the strengths, weakness and direction of the MCH Program for the next five years were solicited. These views were recorded, analyzed and put into the write-up.

B. LAUNCHING THE NEEDS ASSESSMENT

5. The Needs Assessment Begins – A Journey into the Maze

The actual needs assessment can be summed up in a liner fashion in four (4) phases:

- (1) **Phase 1-** Assessment
- (2) **Phase 2** –Data Collection
- (3) **Phase 3** – Data Analysis
- (4) **Phase 4** – Prioritize and Select Problem Areas

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For each of the phases, there is a step that was followed in order to arrive at sound specific needs, from which services could be articulated. The expected output was to be able to clearly identify what type of services, based on needs and resources would be provided for the next cycle of the MCH Program in this simplified table below, as a sample.

	Pregnant	Mothers	Infants	Children	Adolescent	CSN
Direct Services	According to each of the MCH Pyramid, what services should be provided to each of the MCH target groups?					
Enabling Services						
Population based						
Infrastructure building						

PHASE 1: As indicated in the background section, the first phase involved mainly planning and preparation. A quick review of existing data and surveys took place at the National level by the national staff. The final decision was to conduct the needs assessment similar to the process and steps conducted for the last five years, except that much emphasis should be put on the 10 essential public health services.

Again, the same steps taught to the MCH Program coordinators using the q-sort method was employed again this time.

Step 1: Because the needs assessment is a multi-sect oral exercise, the assessment team discussed and identified the stakeholders to be included in the needs assessment. Since the Title V Program works with many other public and private agencies and programs in the community, these programs were asked to participate in the needs assessment. Some of the agencies in the FSM included: the Special Education Program of the Department of Education the Head start Program, the Dental Division, the Family Planning Program, community based nutrition programs such as the Family Food and Nutrition Program (FPPN), the State Statistician, parent groups, and other interested community groups. Since we were not able to secure the funds in time, and because we wanted to have as many representatives as possible to attend the workshops, we aborted our initial plan to bring people together in one place and assembled a team to travel to the four states to do the survey.

Step 2: The assessment team also considered and identified the populations and the geographic areas to be included in the needs assessment. Because the unique geographic configuration of some of the states in the FSM, the needs assessment was performed for the “urban” areas that are close to the central populated areas and for the more remote and rural areas such as the lagoon islands of Chuuk and the outer islands of Pohnpei, Chuuk, and Yap states. The population that was assessed includes (a) Women of childbearing ages, (b) Pregnant

women, (c) Mother of infants, (d) infants 0 – 1 year of age, (e) Children 1-14 years of age. (f) Adolescents 15 – 19, and (g) Children with special needs.

Step 3: The team reviewed the progress reports and needs assessments submitted by the state programs and identified the health status indicators for each of the populations for which data were to be gathered and assessed. Some of the health status indicators for each of the populations were to assess the mortality and common morbidity indicators. For children with special needs, the health status indicator may reflect the functional capability of the child as an indicator.

Step 4: As a result of our review and discussions of the States' progress reports and assessments we were able to define the health services indicators for each of the populations for which data will be gathered and assessed. The health service indicators were categorized by direct health care services, enabling services, population based services, and infrastructure building services. Some of the health service indicators assessed the availability of services, the access to health services, and the access barriers that prevent receiving health services. Surveys, focus group meetings and interviews were developed to collect data needed to assess the barriers to services. The health service indicators that were selected for measuring were indicators that can be changed and corrected.

Step 5: After the health service indicators have been defined, the assessment team was able to identify data sources for each of the indicators selected. Some of the data sources included were the Population Census, Vital Statistics, MCH program data, death certificates, birth certificates, clinic logbooks, and medical records. We were cautious in selecting the indicators to have some reasonable assurance that some level of data was available, therefore a method for collecting the needed data was developed.

Step 6: Finally, since the State MCH Programs completed and submitted the Data Matrix to National MCH Program before the assessment survey, the team reviewed and decided to conduct workshops in order for us to obtain other types of data information that were needed but were not collected or provided by the MCH staff. Since electronic data collection and compilation are not at the state of the art in the FSM, we reviewed records, interviewed people and conduct small group activities during the workshops in order to get what we needed. The State MCH Programs developed and conducted surveys and focus group meetings while the National MCH Program developed questionnaires and conducted face-to- face interviews in order to obtain the qualitative data needed in order to complete the needs assessment.

PHASE 2: Collecting the data was one of the major activities of the needs assessment. It was quite difficult to collect data since we do not have a good electronic system for collecting and compiling data in the FSM. Some of the data collected were not consistent with what was on record, and this was especially true when we reviewed the data from the previous years in order for us to come up with 3 year running averages to determine trends. It took us about two good months to collect data. But on side, the survey for the ten essential public services took only one day to complete by the participants of the workshop.

Step 1: Because the data that were needed to be collected were in several areas, other program staff assisted the MCH Coordinators and the MCH Data Clerks in obtaining and

compiling the required data. Some of the other program staff included the National and State Statisticians, Hospital Statisticians, Dental Services staff, Other Public Health Program staff, such as immunization, nutrition, Family Planning staff, the staff for the DOE – Special Education Program, and the Head start Program, Substance Abuse and Mental Health staff and the department of Public Safety.

Step 2: We focused the Data collection in two areas; quantitative and qualitative data. Quantitative data are essential because they help determine outcomes for each of the performance measures. However, they do not tell us why are we performing or not performing on a specific indicator, thus there is a need to collect qualitative data. For collecting quantitative data, we use the MCH data matrix forms to assure that data is consistent. The data definitions for the MCH data matrix were also used. For collecting qualitative data, focused groups meetings, surveys and face-to-face interviews were conducted. The Focus Group and survey questions were developed to qualify reasoning for the quantitative data collected. The CSN Survey was one of the tools developed to collect qualitative data to respond to the National Performance Measures relating to Children with Special Health Care Needs, which FSM has not been able to respond to for the past years.

Step 3: After we had decided to focus on collecting quantitative and qualitative data, we were concerned, not so much on collecting quantitative data, but on the kinds of qualitative data that we can collect. It should be noted that most of the quantitative data required for us were collected as reflected in the MCH data matrix. However, we were not able to collect qualitative data on all indicators but only on a few. The State MCH Coordinators reviewed the data as it is being collected at the State level to assure that the data collected is collected in a useful format before it is submitted to the National level. In most cases, as it was this year, the data was not carefully reviewed and analyzed at the State level. Thus, the need assessment team reviewed the data to ensure that what was submitted were the data information useful or needed to conduct the needs assessment.

Step 4: After the data had been determined to be useful, the team reviewed the service levels of the MCH Service Pyramid in order to identify and list current services that are available in each of the areas. One of the important components of the needs assessment was to determine and list the availability and accessibility to health care services at each of the MCH service levels. This listing provided below was designed as a matrix with populations on one side and service level on the other side. This matrix was used as part of the analysis and interpretation as well as when selecting the issues and the problems.

PHASE 3: The assessment team did the initial analysis and interpretation of the provisional data, submitted by the state programs, prior to the commencement of the assessment survey. Final analysis and interpretation was made after the team had carried out the survey in all four states and collected all needed data. The analysis and interpretation process included the following steps

Step 1: Because the data collected came in from many different sources, we requested the assistance of the National statistician, hospital statisticians, public health physicians and other clinical staff and education officials, specifically, Special Education and Early Childhood

Education program staff in the analysis and interpretation of the data. Participation of the collaborating agencies is especially important since different programs may have different interpretation of their data sets.

Step 2: In order for us to validate the data collected for accuracy, we had to do a lot of editing since all the states submitted their data matrix based on the 2000 population census. The team felt that by using the 2000 population census figures, we would not be able to present useful data and this has implications when calculating appropriate frequencies, percentages, and rates to compare to other data sets. Since we were assessing the progresses made during the past project cycle, we believe that by using the 2004 projected population, based on the 2000 Population Census, we would be presenting updated and useful data information (denominator) critical for the calculation of percentages, rates and 3-year running averages to gauge progresses and shortfalls.

Step 3: In the analysis of the data, to gauge performance, the team compared the 2005-2008 data (baseline data) with the National Performance Objectives for service indicators. The same data set was used to compare current outcomes with outcomes for the last four years to determine whether or not any progress (s) has been made. The maternal and child health data sets and the Healthy People 2010 Objectives were also used to determine progress made in 2004 as well as progresses made since the 2000 needs assessment.

Step 4: In analyzing the data set for 2004 and the preceding years, some degree of understand or sense of meaning for the numerical parameters evolved. It provided public health meaning to the data by assessing the combination of the quantitative data, the qualitative data, and the service matrix to identify the issues, problems and priorities. The problems are defined as a health status problem, as a lack of a service, as a barrier to access, or as an administrative problem. Problems and issues are defined for each of the population groups and for the appropriate level of service.

PHASE 4: The assessment of the quantitative data and qualitative data and the service matrix helped in determining priority areas and priority issues for the project cycle. This process was done by individual states during the needs assessment survey and repeated in a bigger group with different stakeholders during the 3rd MCH and Special Education joint conference this year.

Step 1: Because establishing priorities involve value systems, a variety of participants with different values provided different perspectives to the issues and problems. The participants who assisted in the prioritizing process included representatives from the four States' MCH Programs, representatives from the States' Department of Health Services – hospital services and public health clinicians and administrators, States' Department of Education – Special Education and Head Start Program, RSAs, Parent groups, Mental Health and Substance Abuse, National divisions of Health and Education.

Step 2: Because there are many different ways to prioritize, the group used a “Reaching Consensus Exercise” model, adopted from a prioritizing exercise during the 2005 AMCHP Conference, to come up with a priority list. The format used in deciding on the issues included presentations, whole group work and discussions, small group work and discussions and

delineation exercise. At the end of the process, the group came up with a list of priority areas and priority issues that the MCH Program will track for the next five years.

6. Assess Needs and Identify Desired Outcome Measures

The comments from the stakeholders ranged from the need to improve quality and availability of services to basic infrastructure needs such as comfortable seating in the clinics. For detailed listing of the needs and issues identified by the State MCH Programs during the face-to-face meeting, by the different layers of services and MCH Pyramid Model, please refer to the tables appended to (at the end) this document.

- 6.1 Table 1: Chuuk State needs and issues
- 6.2 Table 2: Kosrae State needs and issues
- 6.3 Table 3: Pohnpei State needs and issues
- 6.4 Table 4: Yap State needs and issues

Using the 2000 FSM Census as baseline, the 2011 projected population of the FSM stands at 107,581 residents. The distribution of the population among the four states shows that the state with the smallest population is the State of Kosrae with 8,369 residents (7.8% of FSM total); the next largest population is in the State of Yap with 11,836 persons (11% of FSM total); Pohnpei state has a total population of 34,590 (32.2% of FSM total); and the largest population is in the State of Chuuk with 52,786 residents (49.1% of FSM total). Of this total population of 107,581, there are 23,247 women of child-bearing years of 15-44, which is 21.6% of the total population. Of this total population of child-bearing age women, there are 3,806 women between the ages of 15-17 years.

PREGNANT WOMEN - During 2009, there were 2,205 women who were provided prenatal care and who delivered an infant. Of these 2,157 women, 106 were between 15-17 years of age and only 748 (34.7%) received early prenatal care during this year. This is a decrease from 2008 and the cause of the decrease, as reported by the State MCH Staff, was that the service providers were unable to carry out desired number of public awareness campaigns on the importance of early prenatal care during the year due to transportation problems. In addition, the pregnant mothers also reported that lack of transportation, no baby sitter, no health problem, local medicine and no family support are some of the barriers they faced that caused them to come in late. The gender (gender preference) of the service providers is also a problem for most Micronesia women as most women do not like to be seen by a male service provider, for cultural reasons. The data for 2009, although is still high, it represents a declining trend from 2008; however, care must be taken in making an interpretation because of the questionable validity of the birth certificate and death certificate data and the statistical anomaly of the problem with

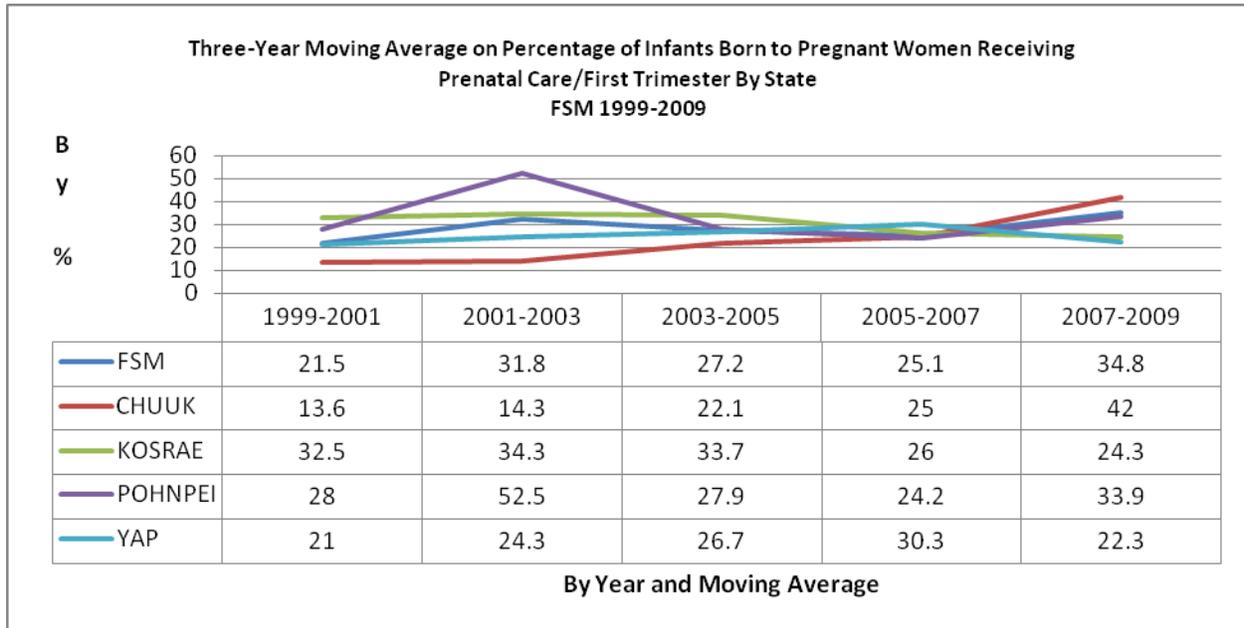
“small number”.

The Kosrae state MCH Program conducted focus group meetings and survey of pregnant women to determine some qualitative information of why pregnant women come in late for their first prenatal care. The focus group involved ten pregnant women who shared their thoughts in reasoning barriers for early prenatal care and late prenatal care. Of those attended the focus group sessions, 70% indicated that pregnancy is just a normal process of women in life unless physical dysfunctions occur then they seek prenatal care service. Aging was another reason for delayed early prenatal care visits. These mothers felt ashamed because women getting pregnant today are in their early child bearing age. A survey was also conducted to determine barriers for early prenatal care services. Among pregnant mothers receiving prenatal care service in 2009, 95 pregnant mothers were surveyed. Of those surveyed, more than 70% were those who came in their late 2nd and 3rd trimester and multiple gravida and para. Based on the survey, the following are the barriers and percentage of respondents; 30% indicated gender preference of service provider, 28% indicated service cost, 15% indicated by personal choice, 8% indicated no health problem, 11% transportation, 3% indicated no baby sitter, another 3% indicated community involvement, 1% indicated use of local medicine and another 1% indicated that PNC is not as important. Another set of questions was focused on service satisfaction. Out of the 95 pregnant women surveyed, more than 75% indicated that they were satisfied with services provided during prenatal care. More than 60% of those indicated satisfaction with services claimed satisfaction was due to health education information and moral support provided at the clinic. Another set of questions was focused on missing appointments during prenatal care. “Forgetful” seemed to be the number one barrier to missing appointments during prenatal care services for pregnant mothers.

Please note that FSM uses data from 2005 to 2009 to assess the percentage or rate of increase or decrease for each of the performance measures and indicators on an annual basis. The data information is clearly stated in the write-up of the needs assessment. However, in assessing the trend of achievement or non-achievement, FSM opted to go back and used data from 1999 to 2009 (doing a 3 year running average) to give more meaning for the data. This strategy is important because of the small population of the FSM and the need to show the achievements and non-achievements made during 2009 compared to the previous year and also the trend toward which the performance measures and indicators are moving. This is noted to avoid confusion when reading the narrative and reviewing the graphs.

In assessing NPM#18, on a 3 year moving average, it revealed that despite the decrease in 2009, there is an increasing trend of infants born to mothers receiving prenatal care beginning in the first trimester as illustrated in the graph below (Figure 1).

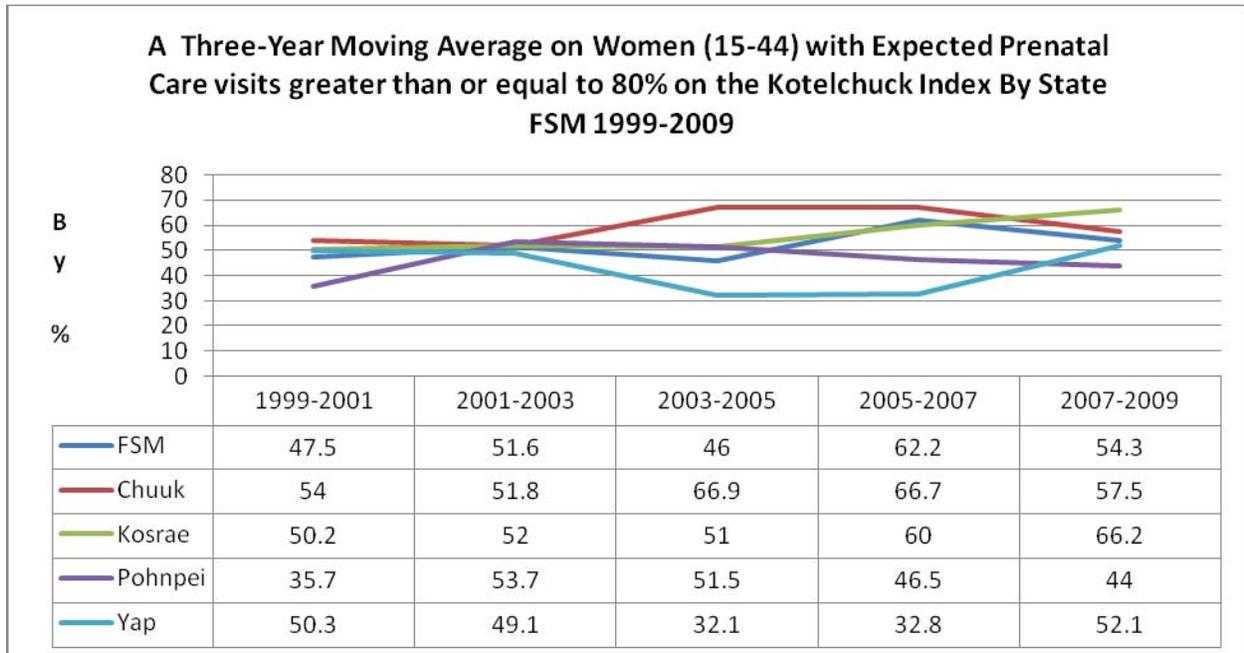
Figure 1



Source: FSM DHSA, MCH Program

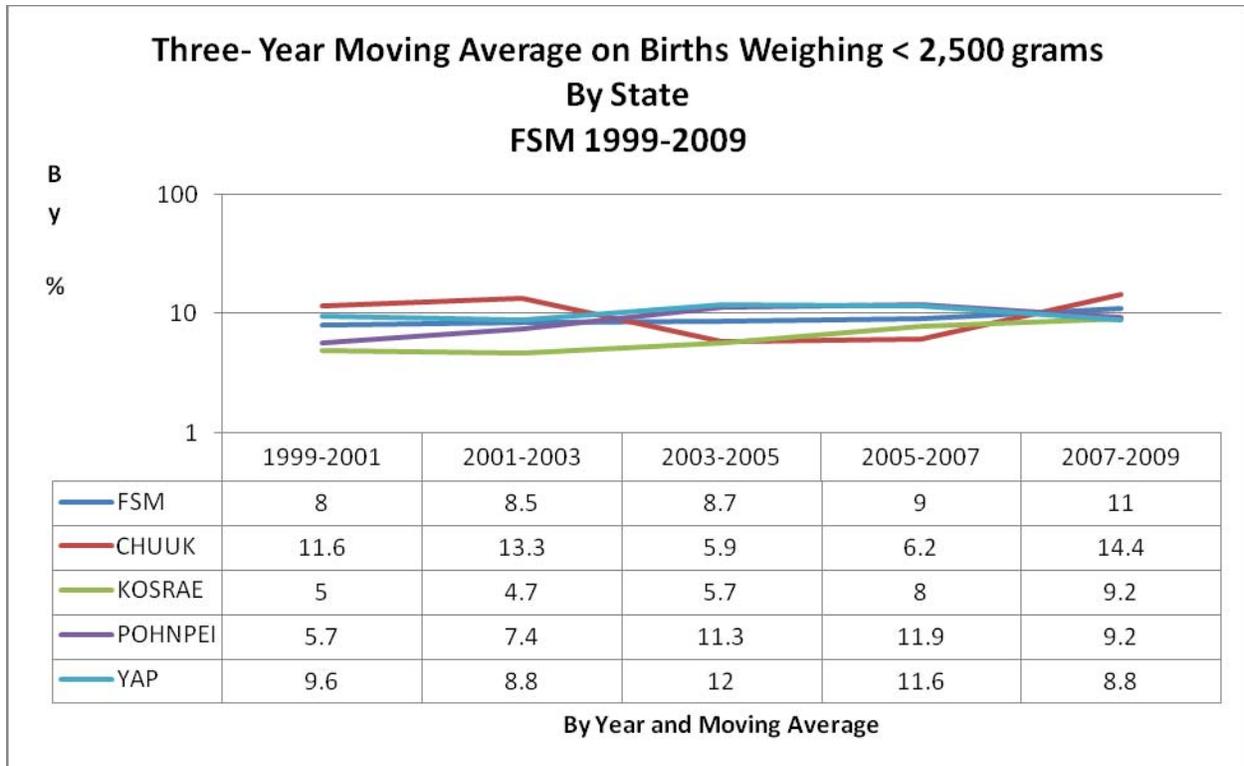
In assessing the Health System Capacity Indicator #4 that measures the number of women who receive at least 80% of their expected number of prenatal visits, 59.6% of the women are receiving those visits, however, this indicator only measures the ratio of observed to expected visits and gives a distorted perspective in that many of these women have initiated care late during their pregnancy. In assessing the data for early initiation of prenatal care and the ratio of observed visits to expected visits based on the Kotelchuk Index of Adequacy of Prenatal Care Services, 26% of the women have received “adequate” care, 18% have received “intermediate” care, and 56% received “inadequate” care. During 2009, there were 2157 women who were provided with prenatal care services of which only 748 or 35% initiated care during the first trimester. The reason why more women did not receive adequate care was because they considered pregnancy as a “normal thing” and not as a sickness and as long as they are not sick, or if you will, feeling well they do not bother to come in for services. Most women seek prenatal care only once or twice before they are delivered. Despite this reality, it was reported that more pregnant women met the expected number of prenatal visit in 2009, and in assessing HSCI # 4 since the last Needs Assessment, the data (based on 3 year running average) showed that, slowly, more and more pregnant women are meeting the expected number of prenatal visit during pregnancy. Please refer to chart below (Figure 2).

Figure 2



Of the 2,157 infants born in 2009, 11.1% were low birth weight, 0.8% were very low birth weight and 28 infants died for an infant mortality rate of 13/1000 which is a decline from the 2008 IMR of 17/1000. The decreased in low birth weight and very low birth weight births in 2009 may be associated with fewer women smoking during the last three months of pregnancy and improved nutrition education and counseling of pregnant women. Though the low birth weight and very low birth weight births may have slightly decreased in 2009, the overall proportion of low birth weight babies has increased and public health intervention activities need to be strengthened. In assessing low birth weight births since the last needs assessment, the data (based on 3 year running average) showed that the percent of babies born in the FSM with low birth weight is slowly increasing. This may have caused by more women smoking since the last needs assessment and the fact that there is no standard protocol for nutrition education and counseling so the quality of the information delivered is basically depended on the experience and knowledge of the service provider. Please refer to graph under Figure 3, of which depicting the progression of this measure on the basis of a three-year moving average (on low birth weights) from 1999 to 2009.

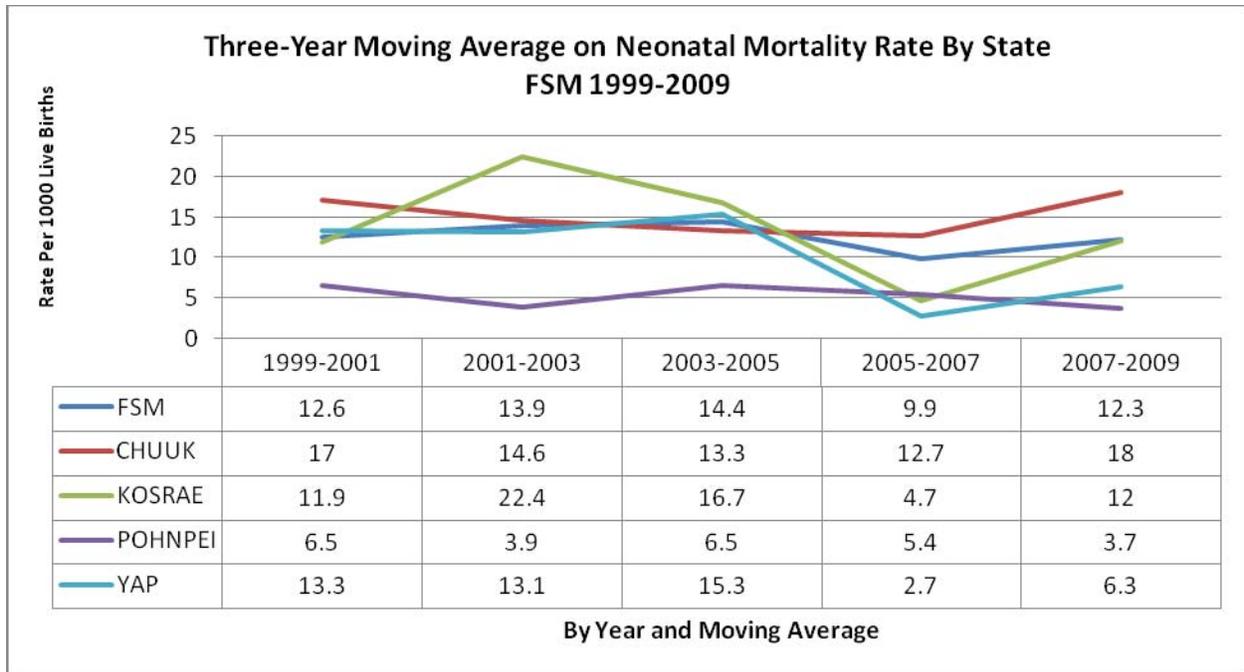
Figure 3



Source: FSM DHSA, MCH Program

Neonatal mortality decreased in 2009 at the rate of 9.3/1000 as compared to 13.7/1000 in 2008. Of the infants who died in the neonatal period, the most common causes were prematurity and congenital anomalies. Post neonatal mortality decreased at 3.7/1000 in 2009 as compared to 4.3/1000 in 2008. Of those infants who died in the post-neonatal period, acute infection was the major cause followed by complications of malnutrition. Because of the association of prenatal care and infant mortality, there is a need to improve the rates of women receiving adequate prenatal care and that the prenatal care services need to be improved and provided in a consistent manner. For neonatal mortality rates on a three-year running average by state and national since 1999 to 2009 can be seen in the graph under Figure 4.

Figure 4



The nutritional status of pregnant women is a critical factor in determining the health of the pregnancy; therefore, there was an attempt to obtain data related to nutrition and pregnancy. All four states reported that all women who attend prenatal care clinics do receive nutrition education services, however, there were no protocols or procedures for nutrition education so the quality of the education depended on the nurse and there was no consistency or quality assurance. The determination of the hematocrit level is one of the routine services that should be provided at the first prenatal visit. However, the MCH Coordinators reported that this service is not consistently provided and sometimes is not done because of lack of supplies. For those women who have low hemoglobin, iron supplements are provided, however, there is no monitoring of whether these women are taking the supplements and a repeat follow-up hematocrit is not performed until the women is in the labor room.

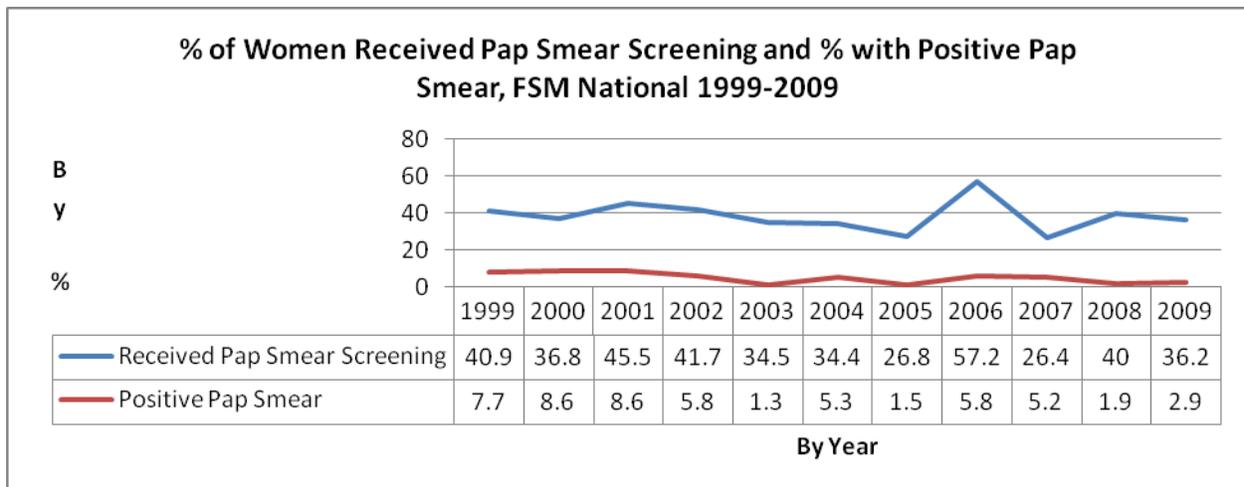
Of the 2,205 women who received prenatal care, 98.7% were screened for low hemoglobin and out of those screened 26.6% were diagnosed with anemia. This reflects a 15.9% decrease from 2008, which is 42.5%. The decrease in the number of women diagnosed with anemia in 2009 may be the result of active and continuous nutrition education and counseling throughout the FSM States aimed at improving the diets of pregnant women and alleviate, if not eradicate iron deficiency anemia. Also, the State MCH Programs have beefed up distribution of ferrous sulfate and Vitamin A supplements.

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Also, 92.8% of pregnant women were screened for hepatitis B and 5.8% were positive, a decrease from 2008, which is 6.6%. The decrease does not really mean that fewer pregnant women have hepatitis B but the States reported to have run out of reagents. Additional funds have been set aside to support purchase of reagents to last the whole year.

Fewer women received Pap smear (36.2%) in 2009 compared to (40%) in 2008. Of those received Pap smear 2.9% were positive, an increase from 2008, which was 1.9% (Figure 5). Pap smear is obtained as part of the screening for the prenatal clinics throughout the FSM States. The decrease in the number of Pap smears obtained in 2009 was a result of shifting the contract to read Pap smear from a laboratory in Hawaii to Lab Tech in Guam. It took longer time to complete processing of such contract so the States started obtaining Pap smears toward the middle of the year. The decrease in the number of positive Pap tests was also due to the late start up for Pap smear reading. Now, that the contract has processed, Pap smears are obtained and shipped out on a regular basis with results returning within about a week. The results are received electronically.

Figure 5

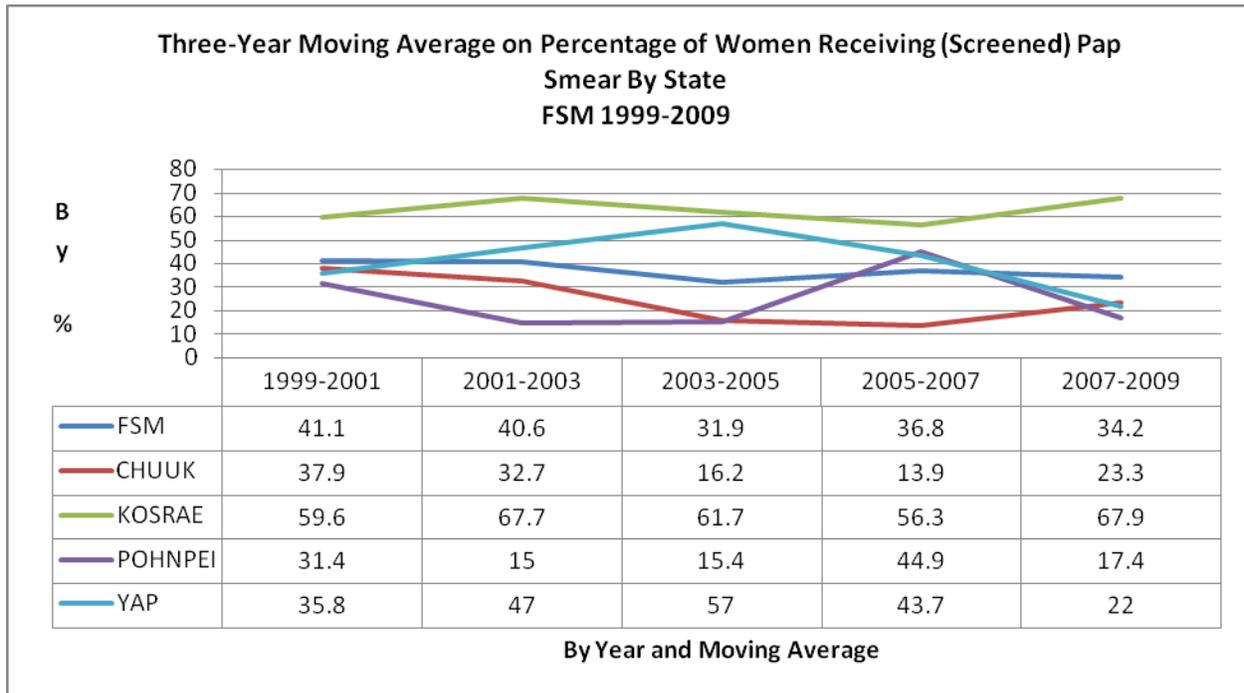


Source: FSM DHSA, MCH Program

On a three-year moving average on these two performance measures, there is, however, indication to the reduction in percentage of positive pap smear, but not with the desired percentage for those who are screened, as presented on the following graphs under Figure 6 and Figure 7.

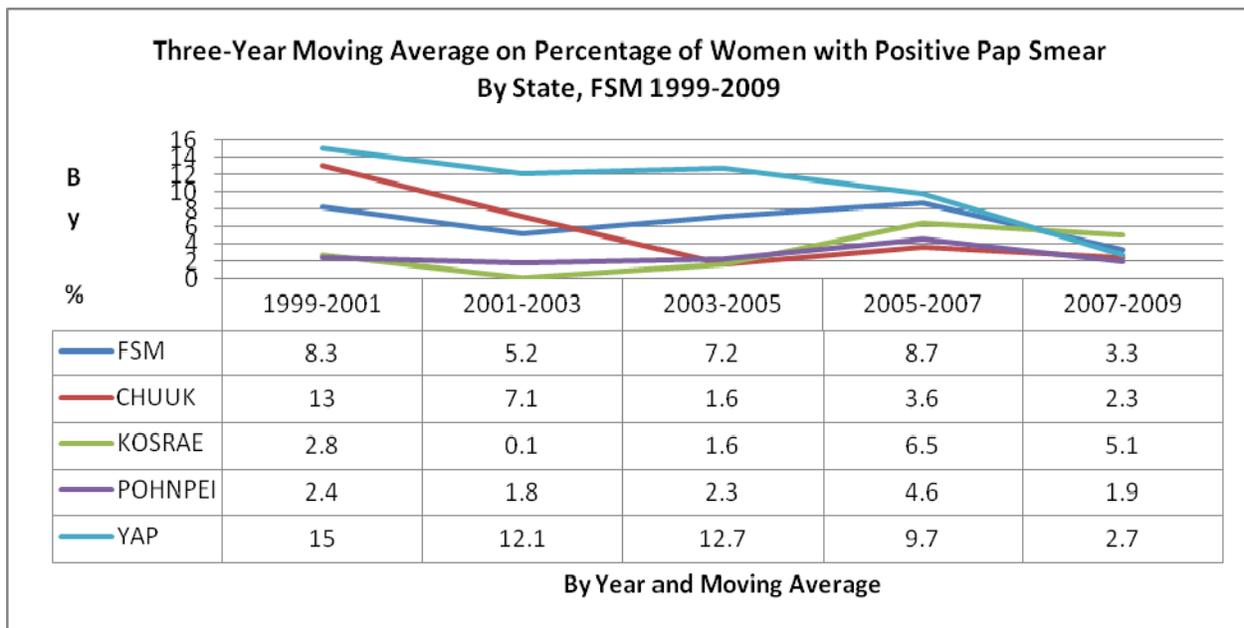
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Figure 6



Source: FSM DHSA, MCH Program

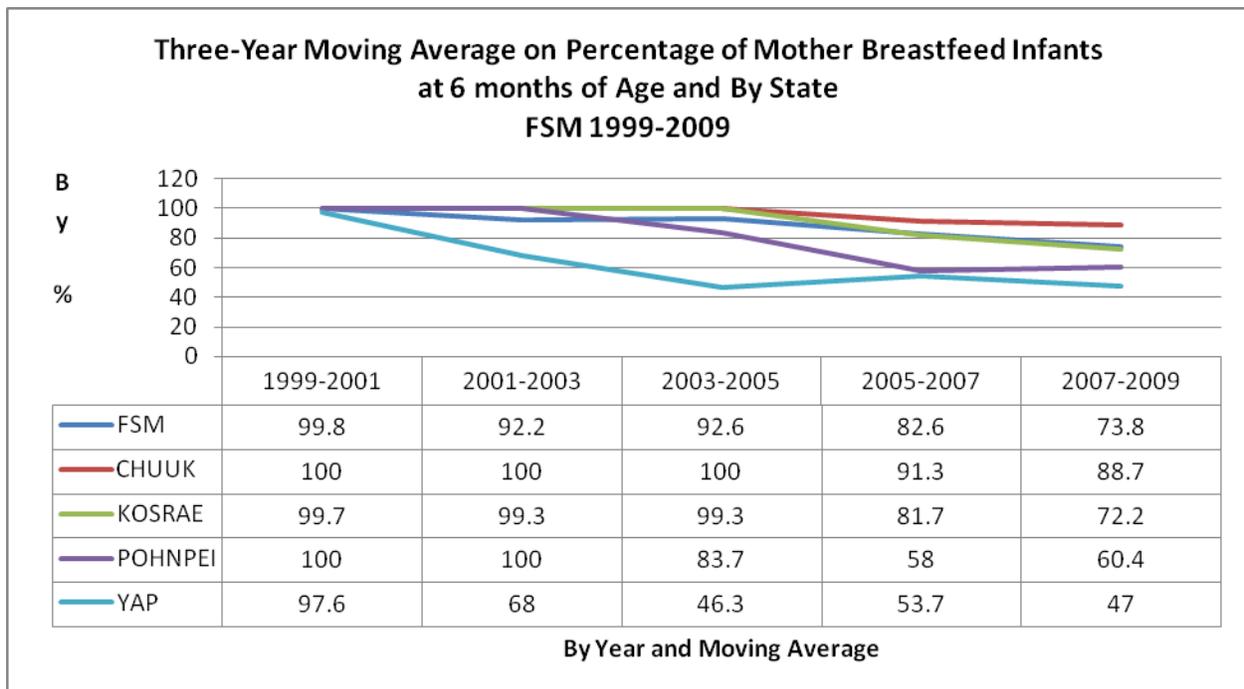
Figure 7



Source: FSM DHSA, MCH Program

The FSM has adopted the WHO policy of assuring that infants are exclusively breastfeeding for the first six months of life and that solid foods are introduced at six months with the continuation of breastfeeding until one year of age. Because of this policy, mothers who deliver a live born are encouraged and supported to breastfeed while in the hospital and mothers are not discharged until the infant is breastfeeding well. For those medical situations where the infant is unable to breastfeed, formula is provided only with a physician’s recommendation and prescription. Therefore, in 2009, in the four FSM states, 73.4% of the infants were being breastfed by their mothers at 6 months of age. On a three-year moving average, however, on this performance measure the current level is at 73.8% as reported in the specified period in Figure 8.

Figure 8



Source: FSM DHSA, MCH Program

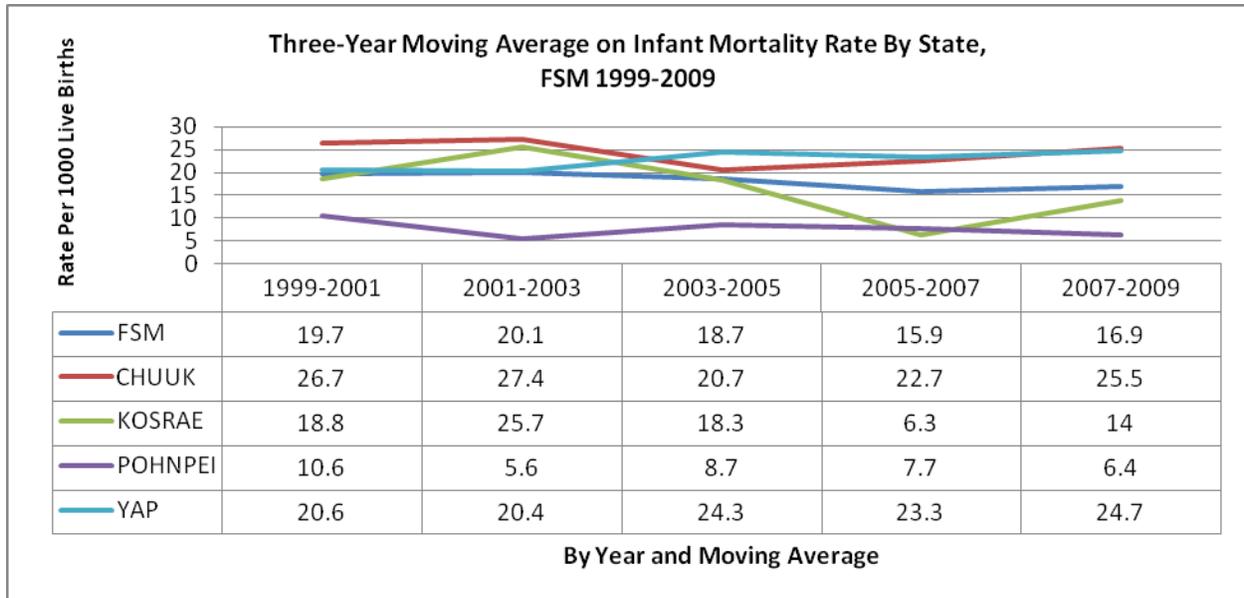
For Chuuk state, in reviewing the cause of death of infants in the neonatal period, it was revealed that the major causes of death were prematurity, infection and malnutrition. The neonatal mortality rate for Chuuk in 2009 is 12/1000. The 2009 rate is lower than in 2008 (25/1000) and 2007 (17/1000), but higher than in 2006, which is 10/1000. Although studies have not been conducted to show the association between the marginal nutritional status of the pregnant women and the adverse outcomes of the pregnancies, clinical data shows that there is a high incidence of iron deficiency anemia among the pregnant women, Vitamin A intake is low, and the diets are marginal. It is suspected that nutritional status does make an impact on not only the high fetal wastage but on the sick newborn as well.

In Kosrae, of the 175 infants born in 2009, 2 infants were born to teenage mothers. Of the 175 infants born, 8.6% were low birth weight and 2.3% was very low birth weight. The Infant mortality rate for 2009 is 23/1000, an increase from 2008, which is 19/1000. The data for 2009, although is still high, it represents a declining trend from 2008; however, care must be taken in making an interpretation because of the questionable validity of the birth certificate and death certificate data and the statistical anomaly of the problem with “small number”.

In Yap, there were 233 infants born in 2009. Of the total new born, 14 infants were born to teenagers, ages 15-17. Of the total infants born, 7.7% were low birth weight and 0.9% was very low birth weight. The Infant mortality rate for 2009 is 17/1000 a big decrease from 2008, which was 24/1000. The data for 2009, although is still high, it represents a declining trend from 2008; however, care must be taken in making an interpretation because of the questionable validity of the birth certificate and death certificate data and the statistical anomaly of the problem with “small number”. In reviewing the cause of death of infants in the neonatal period, it was revealed that the major causes of death were prematurity, infection and malnutrition. The neonatal mortality rate for Yap in 2009 is 2/1000. The 2009 rate is lower than in 2008 (14/1000), 2007 (3/1000), and 2006, which is 4/1000. Although studies have not been conducted to show the association between the marginal nutritional status of the pregnant women and the adverse outcomes of the pregnancies, clinical data shows that there is a high incidence of iron deficiency anemia among the pregnant women, Vitamin A intake is low, and the diets are marginal. It is suspected that nutritional status does make an impact on not only the high fetal wastage but on the sick newborn as well.

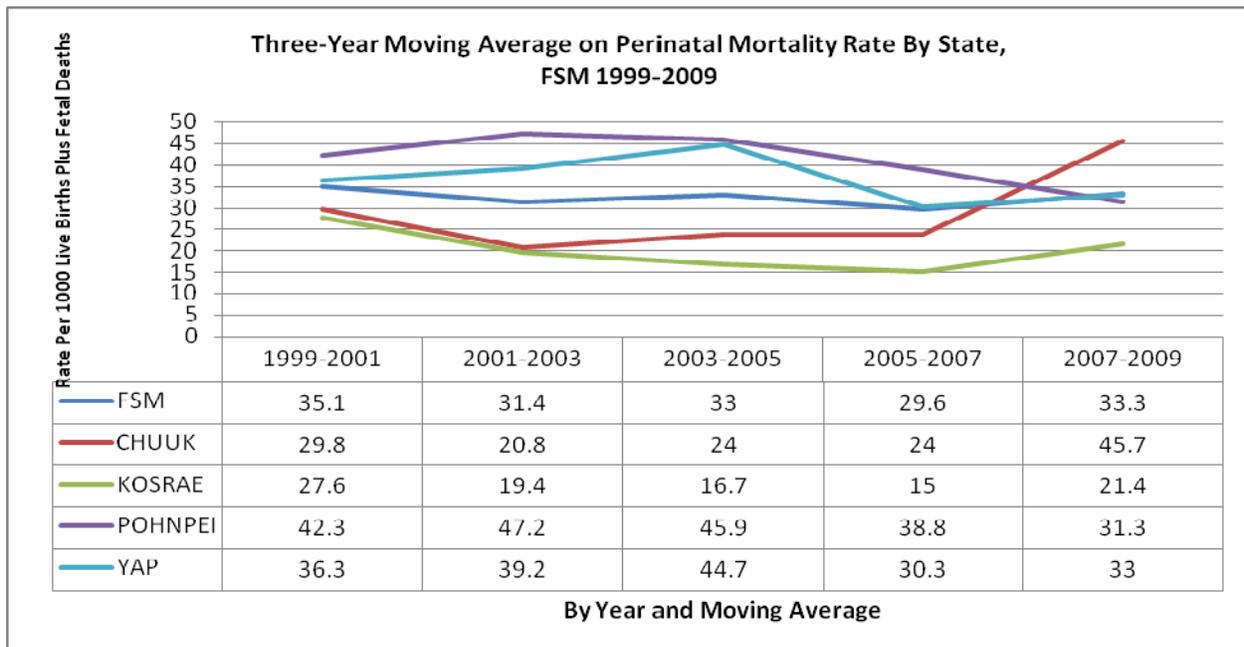
In Pohnpei, there were 891 infants born in 2009. Of the total new born, 44 infants were born to teenagers, ages 15-17. Of the total infants born, 14.4% were low birth weight and 0.7% was very low birth weight. The Infant mortality rate for 2009 is 4/1000 a slight decrease from 2008, which was 4.2/1000. The data for 2009 represents a declining trend from 2007; however, care must be taken in making an interpretation because of the questionable validity of the birth certificate and death certificate data and the statistical anomaly of the problem with “small number”. For Pohnpei state, in reviewing the cause of death of infants in the neonatal period, it was revealed that the major causes of death were prematurity, infection and malnutrition. The neonatal mortality rate for Pohnpei in 2009 is 3.4/1000. The 2009 rate is higher than in 2008 (1.1/1000), and 2006 (2/1000), but lower than 2007, which is 6.7/1000. Although studies have not been conducted to show the association between the marginal nutritional status of the pregnant women and the adverse outcomes of the pregnancies, clinical data shows that there is a high incidence of iron deficiency anemia among the pregnant women, Vitamin A intake is low, and the diets are marginal. It is suspected that nutritional status does make an impact on not only the high fetal wastage but on the sick newborn as well. Figures 9 and 10 present rates for infant and perinatal deaths on a three-year running average from 1999-2009.

Figure 9



Source: FSM DHSA, MCH Program

Figure 10



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Source: FSM DHSA, MCH Program

CHILDREN AND ADOLESCENTS - According to the 2011 projected population

Age	Pohnpei	Kosrae	Chuuk	Yap	Total
0-4	4192	1047	6541	1482	13262
5-9	4320	964	6311	1505	13100
10-14	4177	908	6018	1218	12321
15-19	3573	813	5591	1080	11057
Total	16262	3732	24461	5285	49740

estimates based on the 2000 Census, there are 49,740 persons between the ages of 0 through 19 years which comprises 46.2% of the total population in the FSM. Of this population of persons less than 19 years of age, 38,683 are 14 years old and under and 11,057 are between 15 and 19 years of age. The population in the FSM is a relatively young population where 36% of the total population is made up of children between 0-14 years of age. The overall health status of this childhood population reveals that many children are still being seen in the emergency

room (ER) and outpatient department (OPD) as well as being hospitalized for common infectious illnesses. For example in Pohnpei state, for 2009, the data from the ER/OPD reveals at total of 14372 encounters for children in the 1-14 year old age group. Of these children 2011 visits were for acute upper respiratory infections, 1308 for diarrhea and gastroenteritis, and 826 for Impetigo. During the same time period, there were 8887 encounters for children ages of 0-4. Of these 1452 visits were for acute respiratory infection, 895 visits were for Diarrhea and gastroenteritis, and 631 visits were for acute bronchiolitis. During the same period, 1414 children ages 0-14 were hospitalized. Of these, 138 admissions were for pneumonia, 94 were for diarrhea and gastroenteritis, and 73 were for bacterial sepsis. During the same period, 1105 below 4 years old were hospitalized. Of the total admissions, 123 cases for pneumonia, 73 for bacterial sepsis, and 72 for diarrhea and gastroenteritis combined.

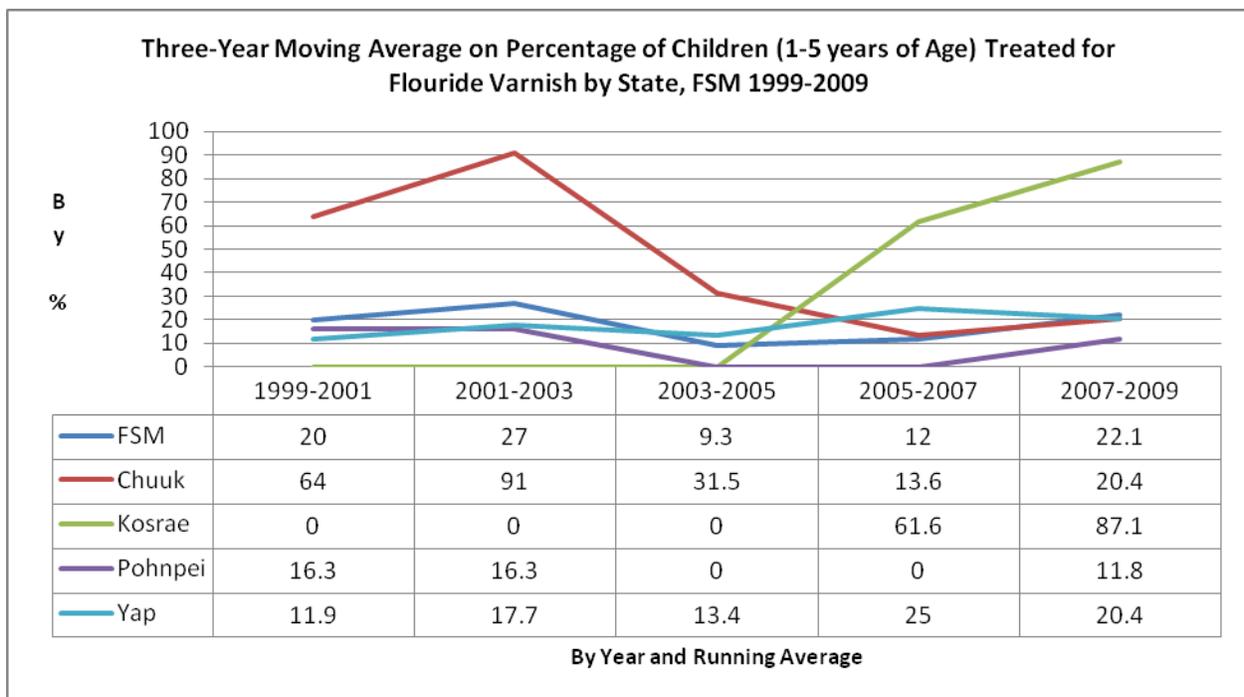
In Chuuk, there were 468 infants hospitalized in 2009 compared to 303 infants in 2008. The most common causes of hospitalizations were dehydration at 31%, asthma at 17%, B. pneumonia at 16%, injuries at 9%, gastroenteritis at 8%, respiratory at 7%, skin disease at 4%, parasitism at 3%, urinary at 2.6%, dengue fever at 2% and musculetal pain at 0.4%.

The MCH program is doing comprehensive health education in schools and communities aimed at informing women of childbearing age about the importance of early prenatal care, pregnant women are continuously being educated and counseled during prenatal clinics and outreach activities on the effects of smoking on the fetus and second hand smoke on children,

and importance of breastfeeding up to 6 months of age, all of which could reduce infants and children morbidity.

In the FSM, the percentage of children 1-5 year old who treated for fluoride varnish was decreased in 2009 at 18.8% compared to 27.3% in 2008. Kosrae state has the highest mark of 88.2% followed by Chuuk (18.3%) and Yap (12.2%). Pohnpei State has the lowest mark at 6.4%. The cause of the decrease in 2009 was due to lack of fluoride varnish. Supplies ran out before the end of the year. The MCH program is working closely with the dental department to ensure that adequate funds are set aside to maintain steady supply of fluoride varnish throughout the year. For the three-year moving average on this particular measure can be noted in the following graph (Figure 11).

Figure 11



Source: FSM DHSA, MCH Program

There was no survey conducted recently in the FSM that can provide us with updated information regarding the dental health of the population that we serve. The most recent and comprehensive studies were the surveys conducted in Chuuk state by Dr. T.H. Aye in 1996-1997 and Dr. M. Takagaki, DDS, from a volunteer agency in Japan, in Kosrae in October 1998 to February 1999. Both dental surveys continue to show high prevalence of dental disease among the children in the FSM and remained one of the major public health problems in all four states of the Federated States of Micronesia. In 2009, the State MCH Programs reported that there were 12 Dentists, 23 Dental Assistants and 11 Dental Nurses for a total of 46 Dental personnel

throughout the FSM States.

Chuuk State reported to have 6 Dentists and 9 Dental Assistants. Kosrae reported to have 2 Dentists and 1 Dental Assistant. Pohnpei reported having 3 Dentist, 8 Dental Assistants and 6 Dental nurses. Yap reported to have 1 Dentist, 5 Dental Assistants and 6 Dental nurses. In Kosrae, in the infant age group (0-5 years) the number of illness was increased in 2009.

For dental caries, 1,676 students from three schools were screened in 2009. Out of those screened, 1,622 have dental caries and 54 are free of caries. Based on the data received from Kosrae Head Start Program, 100% of the 45 students enrolled in 2009 and 2010 school year were screened for dental caries. Of the total screened, 341 teeth were decayed, 65 teeth were filled and 24 teeth missing.

There has not been any up to date survey conducted in the FSM that can provide us with updated information regarding Vitamin A deficiency and iron deficiency anemia since the survey that was conducted in January and February 2,000 by the CDC and Prevention, UNICEF Pacific and the FSM Health Department. The survey assessed the Vitamin A and iron status of 24-59 month old children and their mothers or adult female caregiver in Kosrae and Yap Proper. Serum Vitamin A was measured on 287 children and 207 women from Kosrae and 218 children and 154 women from Yap Proper. The results showed that in Kosrae 57.7% of the children and 58% of the women were deficient in Vitamin A and 13.4 % of the children and 14.4% of the women had low hemoglobin. For Yap Proper 38.1% of the children and 11.7% of the women were deficient in Vitamin A and 11.0% of the children and 18.1% of the women had low hemoglobin. These data clearly indicate the need for programs to address the problems of Vitamin A deficiency and anemia in these two states. Vitamin A supplementation programs are currently in place in the states of Chuuk and Pohnpei.

In 2009, in Kosrae state, the percent of women with low hemoglobin was increased to 48.2% while the three other three States reported decreases. Although there are no data available to assess the status of women and children with vitamin A deficiency, it is apparent that vitamin A deficiency in pregnant women has negative impact on birth outcomes, and poor health status of children. Thus, in 2009, the percent of children with low birth weight in Chuuk was decreased to 9.1% from 27% in 2008, decreased in Kosrae to 8.6% from 10% in 2008, and also decreased in Yap to 7.7% from 8.2% in 2008.

The MCH Program continues to screen all one year olds who return to Public Health for Well Baby Clinic or Immunization for low hematocrit. Those children identified with low hematocrit are given ferrous solution for treatment and the parents or caretakers are also educated on proper nutrition for the babies.

CHILDREN WITH SPECIAL NEEDS - Of the child population 0-21 years of age, who

are potentially eligible for services from the Children with Special Needs Program, there are a total of 1,251 children registered in the CSHN data base in the FSM. These are children who have been screened by various community programs, referred to the CSHN Program, have a completed assessment or in the process of receiving an assessment.

The CSHN is based on an interdisciplinary model that uses a team made up of representatives from the Special Education Program, the Early Childhood Education Program, a Public Health Nurse, a physical therapist, a nutritionist, and a physician and specialty physicians when available. Because of the shortage of staff in all of these areas, it is very difficult to bring the team together to conduct an interdisciplinary assessment, develop the treatment plan, provide the services, and provide the follow-up needed for these children.

Many of these services for these children are provided in the home setting (homebound program) because of the difficulty of transporting these children to the school or to the clinic site. Another difficulty is that not only is there a shortage of staff, but in several of the areas, the staff that is available have not been trained to provide these special services to the children with the special needs. There are also many gaps in the services delivery system for children with special needs because of the lack of trained personnel to provide the specialty care that is required.

Orthopedic services are provided by Shriner's Hospital for Children in Honolulu, Hawaii that provide orthopedic screening and treatment services once a year. A pediatric cardiologist also makes an annual visit to the four FSM states and provides diagnostic and follow-up care for children with cardiac problems. A pediatric audiologist visited FSM this year and provided Audiological Diagnostic Evaluation (DAE) for those children who failed the follow up hearing screening, through the technical support services of the National Center for Hearing Assessment and Management (NCHAM). FSM is desirous to identify and enter into a contract with a pediatric audiologist to ensure that UNHSI national goal #3 (that all infants failing the follow up screening undergo DAE before 3 months of age) is complied with. There are no pediatric neurologists, developmental pediatricians, pediatric ophthalmologists, occupational therapists, audiologists, nor pediatric nutritionist with specialized training in serving children with special needs in the FSM.

7. Examine Strengths and Capacity

The State Title V Agency is in the FSM National Government, which is physically located at Palikir on the island of Pohnpei, six miles away from Kolonia, the center of the state government, and the major commerce and business center of Pohnpei state. The national government, patterned after the U. S. democratic government, has three branches - The Executive Branch, The Judiciary, and the Legislative Branch. The three branches of the government were re-organized in January 1998.

In 2007, there was a change of government. A new administration with new cabinet came to being. Dr Vita A Skilling, a physician and public health advocate, became the Secretary for the new Department of Health and Social Affairs, after “education” became a new department called the Department of Education. In the Department of Health and Social Affairs (DHSA), there are two divisions: Division of Health headed by the Assistant Secretary for Health and the Division of Social Affairs headed by the Assistant Secretary for Social Affairs, which is still vacant until today.

Within the Division of Health, there are six units. The Unit of Family Health is where the MCH Program is directly housed. The Unit Manager, Mr. Dionisio Saimon, also serves as the MCH Program Coordinator. This unit also oversees the Family Planning Program, Hearing Newborn Screening, United National Family Planning Fund, and other small grant activities. At the National, there are five professional staff and administrative support is shared with the other department administrative personnel.

For the purposes of receiving U. S. Federal Domestic Assistance, the National Government is designated as the "State Agency". However, all funds approved by the U. S. Federal Government to support 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 FSM Office of Budget (SBOC). Accounting and funds expenditures is with the Department of Finance and Administration.

Each of the State MCH Program collaborates with the local departments of education, agriculture, social services, Land Grand Nutrition Program annexed to the College of Micronesia-FSM, and Women Interest Officers Program. The collaborations focus on promotion of Vitamin A and nutrition, support services to promote exclusive breastfeeding and parenting skills. Other collaborations with the private organization such as Head Start Program and private schools focus on early dental care services. Through the Immunization Program, the MCH Program in Pohnpei State also collaborates with the Genesis Clinic and the Pohnpei Family Health Clinic by providing vaccines free of charge. In return, the clinics provide immunization data, which is one of the outcome measures for the MCH Program.

Within each of the four states, under the direction of the State Director of Health, the Primary Health Care Services administers the MCH Title V Program. 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. In FY 2005 there were 36 full-time staff and in FY 2009 there were 32 full-time staff in the four FSM States funded by the Title V Program. These include three full-time MCH Coordinators for Chuuk, Kosrae and Yap, the CSHN Coordinators for Pohnpei and Kosrae states, as well as staff positions such as nurses, health educators, health assistants, dental assistants, and clerical staff. The MCH Coordinator for Pohnpei state is funded by Pohnpei State Government. In FY 2006 we request to increase the number to 34 full-time staff, to include a CSHCN Physician and a Nutritionist. FSM has a total of 38 dental staff, among these are 14 dentists, 14 dental nurses and 16 dental assistants. Out of the 38, the MCH Title V Program funds five (5) dental assistants. The Public Health Department provides all of the preventive and primary health care services at no cost to the clients. The staff of the MCH Programs works 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.

During the past years, there have been several changes in the leadership of the MCH and CSHN programs at the state level. In 2000, both Pohnpei state and Yap state replaced their MCH Coordinators. The only incumbents that have been stable are the MCH Coordinator and CSHN Coordinator in Chuuk and the CSHN Coordinator in Yap. These changes in the MCH and CSHN programs have led to a lot of instability in the two programs at the state level. Progress in the implementation of the policy and procedures and services for the Comprehensive Well Baby Clinics and the Children with Special Needs Programs has been significantly hindered because of the need to continually re-orient and re-train new staff.

In 2008, the Pohnpei State MCH Coordinator was reassigned to a new position. The current coordinator has been on the job only for two years. Her background is public health education and nutrition. In Kosrae, a new coordinator came on board in 2005 after the former coordinator became the chief of public health. Chuuk and Yap still have the same coordinators who had been in the jobs since 2004.

Training and education for the coordinators has continued at three levels: (1) Individual on-site consultation has been provided twice a year for the MCH Coordinators and CSHN Coordinators in the four states on developing policy and procedures, program implementation, data collection, data analysis and interpretation, and improving data capacity. (2) The Annual MCH Workshop was held each year from 2005-2010 and brought together the MCH Coordinators, the MCH Data Clerks, the CSHN Coordinators, and staff from the National Government's Health Department where issues were discussed related to improving state data capacity and early intervention services for children with special needs.

The Assistant Secretary for the Division of Health, former National MCH Coordinator, completed educational training in epidemiology at the University of Michigan School of Public Health and continues to provide leadership to the MCH Program in areas of basic epidemiology analysis, program oversight and management.

Also during the past four years, four MCH Data Clerks were added to the four state programs through SSDI Project funding to improve the collection of MCH related data within the states. The data clerks are deployed to the state Medical Records Department and have the primary responsibility for assuring the completion and accuracy of the birth certificates, the fetal death certificates, the infant death certificates, and the pediatric death certificates. The data clerks are also responsible for manually "linking" the infant death and birth certificates. These linked certificates are then given to the MCH Coordinators for analysis and interpretation.

The **Chuuk MCH Program** provides all of the preventive and primary health care services for pregnant women, post-partum women, infants, and children. Pregnant women are provided with prenatal care services twice a week at the central prenatal clinics in Public Health section of the Chuuk State Hospital. The first prenatal care visits are provided on Tuesdays where women are screened for pregnancy risks, hepatitis, Pap smear, and anemia. Revisit prenatal care services are provided on Thursdays for routine prenatal care where nutrition

education, dental services, and physician services are provided. High-risk prenatal clinics are also provided on Thursdays. The Health Assistants in the field provide prenatal care to women in the out-lying islands. Family planning services are provided to those women who attend the post-partum clinics. Well baby care services are provided to infants in Public Health once a week. Services at this clinic include growth monitoring, developmental screening, immunization, nutrition education and counseling. The physician provides physical assessments to all infants who attend the clinic. Services for children are primarily immunization services that are provided both at Public Health and well as by outreach teams in the outer islands. Preventive dental health services are also provided for the children in the schools using staff from the Dental Division and the MCH Program. Children with special needs are seen at a weekly CSHN Clinic by the CSHN physician who provides the medical and health care to the children with disabilities. The program staff also provides services to the children and families in the home when warranted. The CSHN Program has been developed as an interagency effort among the MCH Program, the Chuuk State Hospital, the Special Education Program, and the Head start Program.

The **Kosrae MCH Program** provides all of the preventive and primary health care services for pregnant women, post-partum women, infants, and children. Pregnant women are provided prenatal care services on Tuesdays and Thursdays of each week at the Public Health section of the Kosrae State Hospital. The first prenatal visits are scheduled for Tuesday and the services include monitoring of weight and blood pressure, hematocrit for anemia screening, fasting blood sugar, and Uri analysis. The women are also screened for Hepatitis B, STD's, and cervical cancer with a Pap smear. The tetanus booster is updated and is provided with a physical examination by the physician. Pregnant women who meet the criteria for high risk are referred to the high-risk clinic on the Thursday morning. All the revisits are also done in the Thursday morning clinic. Mothers who have delivered attended the post-partum clinic one month after delivery and are provided with hematocrit screening, blood pressure and weight check, and physical examination. Women are then encouraged to attend the family planning clinic for contraceptive services. Well baby care services are provided on a weekly basis and include growth monitoring, developmental screening, nutrition education, breastfeeding, and immunization. The Children with Special Needs program provides assessment and follow-up services for infants and children who are referred with handicapping conditions. For children who are homebound, the CSHN team will make home visits to provide medical and educational services.

The **Pohnpei Department of Health Services** has three divisions- Primary Health Services Division, Dental Services Division, and Medical Services Division all operating under the State Director of Health Services. The Primary Health Services Division includes all of the dispensaries on Pohnpei proper and also those on the outer islands. Each dispensary is staffed with a health assistant and a nurse. A physician provides medical and consultative services to the dispensaries with visits at least 2-3 times a week. The Medical Services Division provides inpatient services, emergency room services, as well as primary care services through the outpatient clinics. The inpatient services include acute medical care on the medical ward, surgical ward, obstetrical ward, pediatric ward, and newborn nursery. The mental health services are situated outside of the hospital in a building across the street and operate under the supervision of the Chief of Primary Health Services. The CSHN Program is an interagency effort among the MCH Program, the Special Education Program, the Head start Program, and the

physician and physical therapist from the hospital. The Pohnpei MCH Program provides all of the preventive and primary health care services for pregnant women, post-partum women, infants, and children.

The **Pohnpei MCH Program** provides prenatal care, post-partum care, immunization, and children with special needs services. Pregnant women are seen in the prenatal clinics based on their risk status. Services provided during prenatal care include physician examination, weight and blood pressure monitoring, Uri analysis, hematocrit, Pap smear, Hepatitis B screen, and STD screen. Preventive services include prenatal vitamins, iron, diet and nutrition counseling, and care during the pregnancy. Post-partum services are scheduled with the Public Health Clinic at the time that a woman is discharged from the hospital after the delivery. At the post-partum visit, both mother and infants are examined, mother is counseled on breastfeeding, and the mother is referred to the family planning program for counseling and contraceptive services. The infant is given an appointment for the immunization clinic. The Children with Special Needs program provides clinical assessments and follow-up with the physician through the CSHN Program Coordinator. The Pohnpei CSHN Program is an interagency effort among the MCH Program, the Special Education Program, the Head start Program, and the physician and physical therapist from the hospital.

The MCH staffs are part of the teams from Primary Health Division that conduct health screening of children in schools each year. During these screenings, weight and heights are taken, a physician, health assistant, or Medex conducts a physical examination, and visual screening is also done. There are field trips that take these teams to the outer islands to conduct these screenings, however, not on a regular basis.

The **Yap MCH Program** provides all of the preventive and primary health care services for pregnant women, post-partum women, infants, and children. Prenatal care services are provided by the MCH Program on Tuesday, Wednesday, and Thursday of every week. In the outer islands, pregnant women are seen by the health assistants and women who are identified as high risk are referred to Public Health. Prenatal care services include weight and blood pressure monitoring, screening for anemia and Hepatitis B, nutrition education and counseling, and breastfeeding counseling. Well baby care services are provided for all infants and services include growth monitoring, developmental screening, nutrition counseling, and immunizations. The program for Children with Special Needs provides clinical assessment for children suspected of having a handicapping condition. Medical follow-up is provided by the Public Health physician and the CSHN Coordinator, who is a Public Health Nurse. The Yap CSHN Program is an interagency effort among the MCH Program, the Special Education Program, the Head start Program, and the physician and physical therapist from the hospital.

8. Analysis of the Systems of Care – Essential Public Health Services

Besides using the stakeholders' opinions as the measures of strengths and weaknesses of the MCH Program systems in the FSM, evaluating the health delivery system in which the MCH Program operates was also done. This was based on the **Cast-5** methodology as described above, except that the focus was on assessing the essential public health services (see below).

Ten Essential Services of Public Health

- Monitor health status
- Diagnose and investigate
- Inform, educate, and empower
- Mobilize community partnerships
- Develop policies and plans
- Enforce laws and regulations
- Link people to needed services / assure care
- Assure a competent workforce
- Evaluate health services
- Research

Sunday, July 11, 2010

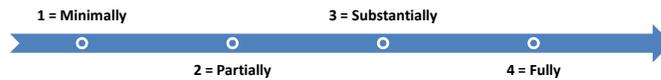
2011-2015 MCH Needs and Capacity Assessment

5

As can be seen in the chart below, essential public health service #1 (EPHS-1) was rated as partially met by all the participants (mean score of 2.5). Pohnpei rated the highest and Yap rated the lowest.

EPHS 1 – Assess and monitor maternal and child health status to identify and address problems

STATE	1.DU1 - Use public health data sets	1.DU2 - Conduct analysis	1.DU3 - Primary data to address	1.DU4 - Interpret data for policy	1.TA1 - Template/standard for core data	1.TA2 - Training about MCH Data	1.TA3 - Assist local health agencies	EPHS 1 - Assess and monitor MCH status to identify and address
P	4	4	2	4	2	2	4	3.1
C	3	3	2	3	3	1	3	2.6
K	3	2	2	2	2	2	3	2.3
Y	1	1	1	2	3	3	2	1.9
N	3	3	3	2	2	2	2	2.4
Mean	2.8	2.6	2	2.6	2.4	2	2.8	2.5



For EPHS 2, the mean score is about the same as EPHS 1. There is no difference from EPHS 1. Both were partially adequate. The ability perform these two essential public health services are not that adequate.

FSM MCH Program – Shaping the Next Generation

EPHS 5 – Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth and other families

STATE	5.DD1 - Use scientific knowledge base	5.DD2 - Provide annual report beyond annual submission	5.DD3 - Formal mechanism to gather public concern	5.DD4 - Use diverse and perspective for planning	5.PD1 - Participate and provide consultation to state initiatives	5.PD2 - Interagency agreement for collaborative roles	5.PD3 - Consultant to new state initiative	5.PD4 - Advocate for programs and policies	EPHS 5 - Provide leadership for priority setting
P	3	3	3	3	2	2	2	1	2.4
C	2	3	3	2	3	2	3	1	2.4
K	2	3	2	2	1	3	2	2	2.1
Y	1	2	2	1	3	3	1	1	1.8
N	2	3	2	2	1	3	2	2	2.1
Mean	2	2.8	2.4	2	2	2.6	2	1.4	2.2



Promoting and enforcing legal requirements to improve the health and safety of women and children was one of the areas rate very low (EPHS-6). Although rated minimally met, it shows that this is an area of concern. The program staff don't normally see that there is conducive environment in which legal requirement is in place to improve the health of women and children.

EPHS 6 – Promote and enforce legal requirements that protect the health and safety of women, children an youth, and ensure public accountability for their well-being

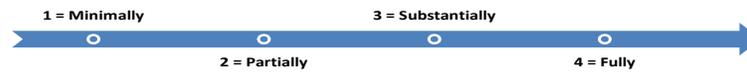
STATE	6.LA1 - Periodically review existing MCH legislations	6.LA2 - Monitored proposed legislation	6.LA3 - Strategy for informing elected officials	6.LA4 - Initiate legislative proposals	6.CS1 - Participate in licensure and certification processes	6.CS2 - Promulgate standards of excellence in quality care for MCH	6.CS3 - Integrate standards of excellence into contracts	6.CS4 - Develop protocols for use by relevant agencies	6.CS5 - Provide oversight for quality assurance
P	1	1	1	1	1	1	1	2	2
C	1	2	1	2	2	1	1	1	1
K	1	2	1	1	1	1	2	2	2
Y	1	1	1	1	2	1	1	1	1
N	1	2	1	1	1	1	2	2	2
Mean	1	1.6	1	1.2	1.4	1	1.4	1.6	1.6



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EPHS 8 – Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address MCH needs

STATE	8.CP1 - Relationship with training institutions	8.CP2 - Monitor MCH labor force available	8.CP3 - Monitor facility and training programs distribution	8.CP4 - Integrate information with health status needs assessment	8.CP5 - Incentives to address workforce needs	8.CM1 - Make available and support CE for targeted professionals	8.CM2 - Play leadership role in establishing professional competencies	EPHS 8 - Assure capacity and competency of workforce
P	2	1	1	1	1	1	2	1.3
C	2	3	3	3	2	2	3	2.6
K	1	1	2	2	1	2	1	1.4
Y	2	1	1	1	1	3	3	1.7
N	1	1	2	2	2	1	1	1.4
Mean	1.6	1.4	1.8	1.8	1.4	1.8	2	1.7



When it comes to evaluation (EPHS-9), all the states indicated that their ability to evaluate MCH Program activities is partially adequate. Chuuk and Kosrae seem to have the highest scores while Pohnpei has the lowest. It should also be pointed out that the National government also indicated that its capacity is “partially” adequate. One would expect that National government should score the highest among all states since this is an area of responsibility for the FSM National government.

EPHS 9 – Evaluate the effectiveness, accessibility, and quality of personal health and population-based MCH services

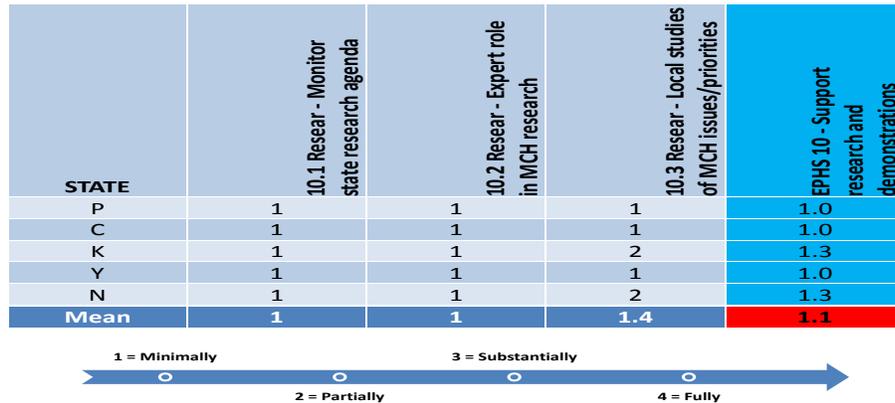
STATE	9.1 Eval - Routine monitoring and structured evaluations	9.2 Eval - TA to local agencies in conducting evaluations	9.3 Eval - Collaborate with local agencies in consumer satisfaction	9.4 Eval - Perform comparative analysis of programs and services	9.5 Eval - Disseminate information on MCH services effectiveness	9.6 Eval - Utilize data for quality improvement	9.7 Eval - Leadership in disseminating MCH outcomes from private sector	EPHS 9 - Evaluate effectiveness, accessibility, and quality
P	2	1	1	1	1	1	1	1.1
C	3	2	3	2	3	4	3	2.9
K	2	1	2	3	3	3	3	2.4
Y	3	1	2	1	3	2	1	1.9
N	2	1	2	3	3	3	3	2.4
Mean	2.4	1.2	2	2	2.6	2.6	2.2	2.1



Supporting research (EPHS-10) is the lowest. This means that there has not been any activity that the MCH Program at the National or the state level supports to better understand

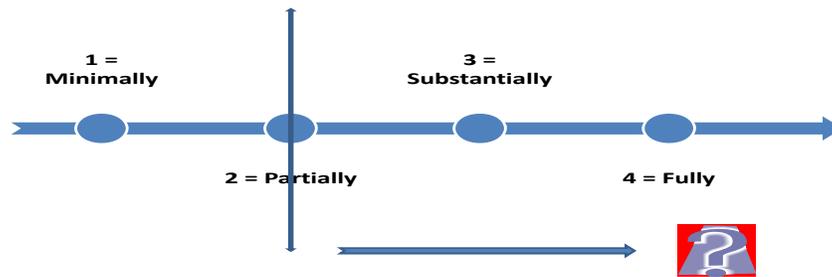
or improve the health of women, infant, and children. This statement is not to mean that there has not been any research activity in general, it just means that the MCH Program has not been directly involved in research.

EPHS 10 – Support research and demonstration to gain new insights and innovative solutions to MCH related problems



The impression that one can conclude from this assessment exercise is that the essential public health services are “partially” met. A few of the public health functions which are critical components of a well established MCH Program System are only minimally met.

Impression & Findings



The challenge is how to move to improve these EPHS that were minimally adequate to fully adequate, as the chart below visually depicts. This was the philosophical and bigger picture that the Assessment Team, especially the FSM Department of Health and Social Affairs, posed to the partners during the face-to-face needs assessment meeting.

As a public health program, MCH Program is often perceived as a stand along program implemented in each of the FSM states. There is a great need to improve the health of the MCH Population in the entire nation, but to transform the system in which the MCH Program exists in order to gauge progress of the MCH Program is a job that requires sectoral approach.

The recommendations fall in some broad areas and they include the following:

1. The MCH Program needs to better define what specific services must be provided given the limited resources available with its program and resources available within the environment the MCH Program operates.
2. Since the MCH Program involves a multi-level of partners and agencies, coordination with other agencies and service providers is critical. Often times, coordination and collaboration are viewed as pushing the obligation or responsibilities to other agencies.
3. Often times the MCH Program sees itself trying to influence change that is not within its means or resources. Or sometimes, the MCH Program set itself in such a way that the result of its actions depend on others. It is recommended that the MCH Program should focus its resources and attentions on activities and services that are doable or within its means.
4. When expecting “partners” to do certain activities, partners must contribute or put up resources. Likewise, when the MCH Program is expected to partner with other agencies in some events or activities, it has to commit by providing time and resources; otherwise, such partnership does not exist.
5. Outreach activities need to improve from the past years. Review of clinic records shows that there was little outreach activity conducted by the MCH Program during these years. Even if the administration of the MCH Program in each of the FSM states are centralized, efforts must be done to bring the services to the women, infants and children in the rural parts of the nation.
6. The MCH Program staffs need training to increase their technical capacity in areas such as women’s health, pediatrics, program management and evaluation. The fact that there is a new early hearing screening program part of the MCH Program is promising but needs to be sustained in order to have a greater impact.

9. Select Priorities

DIRECT HEALTH CARE SERVICES - The MCH Program in the four FSM states continues to provide a large segment of the direct health care and enabling services for the maternal and infant population.

Between April and May this year, the FSM MCH Program conducted a five-years needs assessment. The findings of that needs assessment lead to some important deficiencies, within the health care system, and to some specific health issues that the MCH Program focused its resources and activities as its priorities. The issues that were noted in the needs assessment were also augmented by recommendation from other experts to the FSM government for the need to

provide coordinated and persistent array of social, medical and preventive services to improve the health of the women, mothers, infants and children who make up at least 97% of its total population.

The Assessment Survey was completed during June 2010. Generally, the purpose of the Assessment was to determine the service requirements within the FSM. The study was aimed at determining;

- 1) What was essential in terms of the provision of health services,
- 2) What was available, and
- 3) What was missing.

The findings of the Needs Assessment Survey were presented during the FSM MCH Annual Workshop during the month of June in Chuuk State during which time the Priorities for the next five years were selected.

The assessment of services for pregnant women shows that only 34.7% of the women received early prenatal care, a decline from 2008 when 40.4% of pregnant women received early prenatal care. For those women who do initiate care, only 28% receive adequate care, 12% receive intermediate care, and 60% receive inadequate care as measured by the Kotelchuk Index of Adequacy of Prenatal Care. The nutritional status of pregnant women has been a problem; however, there is no formal documentation of the problems. Informal surveys of hematocrit levels of pregnant women in Chuuk state show that approximately 23% of the women have low hemoglobin that require treatment. There is a need to improve the adequacy of prenatal care by encouraging early prenatal care and continuous prenatal care. In 2009, 8% of all those women who gave birth never received prenatal care. Of all these those who received prenatal care only 28% received adequate prenatal care, 12% received intermediate prenatal care and 60% received inadequate prenatal care as determined by the Kotelchuk Index.

Of the infants born in 2009, 11% were low birth weight, 0.8% were very low birth weight and 28 infants died for an infant mortality rate of 13/1000 which is a decline from the 2008 IMR of 17/1000, 2007 IMR of 20.6/1000, and the 2005 IMR of 16/1000. Of the infants who died in the neonatal period, the most common causes were prematurity and congenital anomalies. Of those infants who died in the post-neonatal period, acute infection was the major cause followed by complications of malnutrition. Because of the association of prenatal care and infant mortality, there is a need to improve the rates of women receiving adequate prenatal care and that the prenatal care services need to be improved and provided in a consistent manner. Of the 2,157 infants born in 2009, 11% were low birth weight (LBW) and 0.8% very low birth weight (VLBW) (<1500 grams). Though the VLBW may have slightly decreased from 2007 (1%), the overall proportion of low birth weight babies has increased and public health intervention activities need to be strengthened, not lessened.

Dental disease among children remains one of the major public health problems in all four FSM states. Recent surveys have shown that approximately 80% of young children have significant dental disease. There is a need to assure that children are screened for dental disease and appropriate referrals for restoration and treatment are made to the dental program.

Vitamin A deficiency and iron deficiency anemia are emerging health problems among children as well. In 2009, about 27% of children 1 year and younger were reported to have anemia. Chuuk State reported having the highest at about 46%, followed by Kosrae at about 25%, and Pohnpei at 25%. Yap State reported the lowest at 13%. Because Vitamin A deficiency and iron deficiency anemia are only indicators of other underlying nutritional deficiencies, there is a need to improve the overall nutritional status of children.

ENABLING SERVICES - Enabling services are those that facilitate the access to direct health care and in the FSM are usually limited to transportation, outreach, health education, and care coordination. For pregnant women in the FSM, a qualitative survey suggests that the barriers to receiving early prenatal care include the lack of transportation, lack of child-care, use of local medicine and gender of service provider. Therefore, there is a need to increase the outreach efforts to assure that women living in remote areas have access to care. This can be achieved by providing resources for transportation to prenatal clinics or for outreach teams of physicians, public health nurses, and health educators to provide these services in the field. In the FSM, where everyone knows everybody else and traditional customs are still very strong, most women do not want to be seen or examined by a male provider, worse yet, a provider who is a relative. There is a need to increase the number of female providers to assure that all women have access to care. Local medicine should be encouraged only after a woman has seen a physician.

The FSM has adopted the WHO policy of exclusive breastfeeding of infants for the first six months of life. The data shows that about 73% of the infants in the FSM are breastfed at 6 months of age. The two states that have the highest percentages of infants breastfeeding at six months of age also have implemented a community-9 based breastfeeding support program. The model uses older women who live in the community that are trained by the MCH staff to provide the education and support for young mothers who have been discharged home. These women are notified when a mother is discharged and make an initial home visit within 48 hours. Those mothers are provided with education and demonstrations on breastfeeding and if necessary, repeat home visits are made. There is a need to expand this model of community-based support using this traditional cultural method to all communities in the four FSM states. The 2009 data showed that 100% of mothers breastfed at discharge from the hospital, but at 6 months of age the percentage decreased to 73%.

For children with special needs, there is a need to continue to provide home visiting and care coordination services for those children who have a severe disability and are receiving homebound services from the Department of Education's Special Education Program.

POPULATION -BASED SERVICES - These services are preventive services that are available to the entire MCH population and include disease prevention, health promotion, and statewide outreach.

With the high prevalence of dental disease among the young children in all of the four FSM states, there is a drastic need for the MCH Program to coordinate with the dentists and Dental Division staff to plan, develop and implement a comprehensive Childhood Oral Health Program in the Federated States of Micronesia. This program will include the following major components: (1) Assuring a comprehensive multi-media community based awareness and education program; (2) A comprehensive preventive well baby care program with multivitamins with fluoride, educating the caretakers on good nutrition, good oral health practices; (3) A school based fluoride and toothbrush program; and (4) Improving access to restorative and treatment dental care. When completed, such plan would require (compulsory) all children between ages 3-6 years to complete their dental services before entering grade 1.

Vitamin A deficiency and iron deficiency anemia is an emerging major health problem that is becoming more evident in the maternal and child population. A survey was conducted in January and February 2007 showed that in Kosrae 57.7% of the children and 58% of the women were deficient in Vitamin A and 13.4 % of the children and 25% of the women had low hemoglobin. For Yap Proper 38.1% of the children and 11.7% of the women were deficient in Vitamin A and 11.0% of the children and 15.1% of the women had low hemoglobin. These data indicate the need to improve the nutritional status of the MCH population through health education and health promotion models.

Screening services for pregnant and post-partum women include Pap smear screening, Chlamydia screening, STD screening, and Hepatitis B screening, however, there are no consistent procedures to assure that all women are provided with the full complement of screening services. There is a need to continue this collaboration among all of the programs including the MCH Program to assure that these screening services are provided consistently to the pregnant women population.

INFRASTRUCTURE BUILDING SERVICES - Activities for developing and maintaining comprehensive systems of services such as developing standards and guidelines, training, data systems, policy and procedures, and quality assurance.

Under the SSDI Project, the four FSM states have developed systems of care through the development of a Children with Special Needs Program and a comprehensive Well Baby Clinic

Program. As part of improving the adequacy of prenatal care for pregnant women, there is a need to develop a system of care for this population by developing a common set of policy and procedures, common definitions and data collecting systems, common educational modules and materials, and training for staff to implement these changes.

Children with special needs require an interdisciplinary team of professionals, however, there is a serious lack of appropriately trained professionals to be able to provide the services that are often required by these children who have serious illnesses and require specialized care. FSM has hired a CSHCN Physician. Although the physician was not be able to provide those specialized services due to unavailability of resources, such as equipment, etc., most of the needs of this population group was able to be provided on a regular and timely basis. There is a need to develop an alternative model of providing care to this population. The Pacific Open Learning Health Net (POLHN), an open computer system implemented by the World Health Organization (WHO), now available to the four FSM States' Public Health Services. The purpose of the POLHN is to provide an alternative method of technical assistance and on-going support to the Pacific Islands. This alternative method is based on several factor; (1) the emerging technology of advance telecommunications; (2) the telecommunication capabilities in the Pacific Basin; and (3) the difficulty in providing technical assistance to all of the Pacific Jurisdictions because of the distances and expenses involved.

Basically, the assessment of the data shows that the health status of the MCH Population had not improved substantially. In fact, in some areas it shows that health status outcomes had worsened.

Based on the findings of the MCH needs assessment, SWON Survey, assessment of the Health Status Indicators, and other data, FSM identified eight (8) priority areas for which resources will be allocated during the next five years. The priorities were selected based on careful and through assessment of our achievements on the past program cycle's priorities and each State's experience in working toward achieving these priorities. The priorities identified include:

1. To increase the percentage of pregnant women attending Antenatal Care in the first trimester.
2. To decrease Infant Mortality.
3. To improve the nutritional status of the MCH population.
4. To increase the percentage of immunization coverage.
5. To decrease incidence of STIs in among the MCH population.
6. To decrease the rate of teenage pregnancy.
7. To improve Oral Health status among the MCH population.
8. To improve the number of Newborns screened or diagnosed with potential hearing loss for early intervention services.

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Based on the analysis and conclusions of the MCH needs assessment, SWON Survey, the data elements of the MCH Data Matrix, and the MCH priority needs, the FSM MCH Program was able to identify its State Negotiated Performance Measures. The selection of the State Negotiated Performance Measures was determined based on FSM's achievements on the various data elements of the MCH Data Matrix during the past cycle and each States experience and need in dealing with its own MCH population. It should be noted that some of the State Negotiated Performance Measures identified were based on hunch or suspicion. For example, in the process of identifying the State Negotiated Performance Measures, Chuuk State indicated that they suspected that they may have high maternal mortality rate and therefore is interested to track "maternal deaths" to verify it. Because there is no data to support this, the other states, nonetheless agreed to it and "maternal death" was added to the list. The FSM States, based on the review of their achievements on the past program cycle's State Negotiated Performance Measures decided to migrate some of the old performances into the current program cycle as well as add new ones. Ultimately, they maintained all but one State Negotiated Performance Measures from the past cycle and add two new measures.

SPM#1. The percent of women receiving services in the MCH Programs who receive a Pap smear. (Maintain)

SPM#2. Percent of pregnant women who have been screened for Hepatitis B surface antigen. (Replace)

SPM#3. Percent of infants who are exclusively breast fed at 6 months of age. (Replace)

SPM#4. Percent of pregnant women who receive at least one nutrition education and counseling session as early as possible during their pregnancy. (Replace)

SPM#5. Percent of caretakers of infants who receive education and counseling related to feeding and nutrition of infants. (Replace)

SPM#6. Percent of children enrolled in Early Childhood Education Program (Head Start) surveyed to determine the rate of decayed, missing or filled teeth. (Replace)

SPM#7. Percent of children with identified developmental problems who are admitted to the CSHCN Program. (Maintain)

SPM#8. Percent pregnant women attending prenatal care who are screened for low hemoglobin. (Maintain)

SPM#9. Percent infants who received at least six bottles (1 bottle/30 days) of fluoride in the first year of life. (Maintain)

SPM#10. Percent of children with special needs who have a completed reevaluation by

the CSN team within the last 12 months. (Maintain)

SPM#11. Percent of women of child-bearing age who attended workshops in the schools and communities during the reporting period. (Maintain)

SPM#12. The rate of maternal deaths in the reporting year. (Maintain)

SPM#13. The percent of one year old babies with anemia. (Maintain)

FSM is proposing to add two new State Negotiated Performance Measures based on the outcome of the Needs Assessment. The rationale behind these two new State Negotiated Measures are 1) Rheumatic Fever is an emerging issue in the FSM and 2) given the high rate of pregnant women with anemia, the State MCH Program staff decided that it only make sense to begin to screen and treat women of child bearing age with anemia earlier, rather than to wait and treat them later when they are pregnant. Obviously, in the FSM, it has always been a challenge to have the pregnant women come in for prenatal during the first trimester. Hence, FSM is proposing to add new SPM# 9 and SPM#10 as follow:

1. SPM#9 - Percent of children 5-21 years old diagnosed with Rheumatic Fever (New)
2. SPM#10- Percent of Childbearing Women with Anemia, <35hct. (New)

These sets of priorities will be FSM's priorities for the next five years based on the result of the needs assessment carried out this year. Basically, the needs assessment was a reexamination and assessment of how and where program shortfall came about during the last program cycle in terms of service requirements within the FSM as determined in the 2010 needs assessment. This year's needs assessment also helped us to determine the service requirements within the FSM for the next program cycle in terms of 1) what is essential in terms of the provision of health services, 2) what is available and 3) what is missing. In addition, since the year 2011 will mark the beginning of the next 5-year cycle of our MCH Program, we will continue to address the regular direct medical and preventive health services through its prenatal clinic, well baby clinic, out-reach activities, and dental clinic in form of "lessons learned".

Discussion of State Performance Measures.

SP#1 - Percent of women who receive a Pap smear. This measure was maintained because of its importance in assuring the overall health status of the women of child-bearing age. This measure is associated or linked with the priority need # 5 to decrease the incidence of STI. The level of service is population-based and the type of service is a risk factor.

SP#2 - Percent of pregnant women screened for Hepatitis B. This measure was replaced because the FSM State MCH Programs felt that they have been performing very well on this measure for the past several years and there is not need to track it any longer. FSM will not track

this State Performance Measure during the next program cycle.

SP#3 - Percent of infants exclusively breastfeeding at six months. This measure was replaced because it became one of the National Performance Measures (NPM#11).

SP#4 - Percent of pregnant women who receive nutrition education. This measure was replaced because the State MCH Programs felt that they have been performing very well on this measure for the past several years and there is no need to track it any longer.

SP#5 - Percent of infant caretakers who receive nutrition education. This measure was replaced because the State MCH Programs felt that they have been performing very well on this measure for the past several years and there is not need to track it any longer.

SP#8 - Percent of pregnant women screened for low hemoglobin. This measure was maintained because low hemoglobin and iron deficiency anemia is an indicator of a state of nutritional risk. In a pregnant women, this risk may have a detrimental impact on the developing fetus and the newborn infant. The long term consequences of low hemoglobin in the pregnant woman may be reflected in the development of iron deficiency anemia in the infant before six months of age. This measure is associated or linked with priority #3 to improve the nutritional status of the MCH Population and may contribute in the decrease of infant mortality rates. This measure is a population based service and the type of service is risk factor.

SP#10 - Percent of children with special needs who have a completed re-evaluation by the CSHN Team within the last 12 months. This measure was maintained because of need to assure that children with special needs have a periodic re-evaluation by an interdisciplinary team of professionals. The special needs of these children are constantly changing depending on their response to treatment and rehabilitation. This periodic re-evaluation will assure that any developmental progress is documented and any new special needs are addressed. This measure is associated or linked to priority #8 to increase the number of newborns screened, diagnosed for potential hearing loss for early intervention services. This measure is an enabling service and the type of service is a process.

SP#6 - Percent children identified with developmental problems. This measure was maintained because of the need to assure that all infants up to 18 months of age receive developmental screening to screen for developmental delay. This activity will continue to be reinforced and encouraged to assist in the earlier identification of children who are suspected of having a handicapping condition. This measure is an enabling service and the type of service is a process.

SP#7- Dental Health survey. This measure was replaced because the State MCH Programs were having difficulty in tracking this performance measure. The State MCH Program staffs were unable to agree on the Numerator and Denominator and annual rates have been very poor. It seemed, as though, FSM was setting itself up for failure. Based on recommendation during the 2007 MCH Grant Review FSM replaced this measure.

SP#9 - Comprehensive Health Education in Schools and Communities. This measure is maintained because of the importance in assuring that all pregnant mothers come in early for prenatal care. This measure is associated or linked with the priority # 1 to increase the percent of pregnant women attending ANC in the 1st trimester. The level of service is population-based and the type of service is a risk factor.

SPM#12. - The rate of maternal deaths in the reporting year. This measure was maintained because FSM felt that it was important to track maternal death and causes of maternal deaths in the FSM. In addition, FSM is required to file a report, each year, for the Millennium Development Goals and the FSM MCH Program was tasked to collect this indicator for the FSM. This measure is associated or linked to priority # 6 to decrease teen pregnancy. The level of service is population based and the type of service is a risk factor.

SPM#13. - The percent of one year old babies with anemia. This measure was maintained because anemia with babies is an emerging issue in the FSM. More and more babies are diagnosed with anemia which may be associated with the quality of prenatal care services and nutrition intake of pregnant mothers and decreasing number of mothers who breastfed at six months of age. This measure is associated or linked with priority #3 to improve the nutritional status of the MCH population. The level of service is population based and the type of service is a risk factor.

SPM#9 - Percent of children 5-21 years old diagnosed with Rheumatic Fever – (Proposed) This new performance measure was added because rheumatic fever is an emerging issue in the FSM. The State MCH programs suspected that most of the rheumatic fever cases are within this age group, so they want to track to confirm and find out underlying causes to prevent it. This measure is associated or linked with priority # 2 to decrease the high infant mortality rate. The level of service is population based and the type of service is a risk factor.

SPM#10- Percent of Childbearing Women with Anemia, <35hct. – (Proposed) This new performance was added because FSM is experiencing increasing number of pregnant women with anemia. The State MCH programs felt that it would be best to screening and treat the women of childbearing age who have anemia earlier and not to wait until they are pregnant. This measure is associated or linked with priority # 3 to improve the nutritional status of the MCH population. The level of service is population based and the type of service is a risk factor.

10. Select Targets

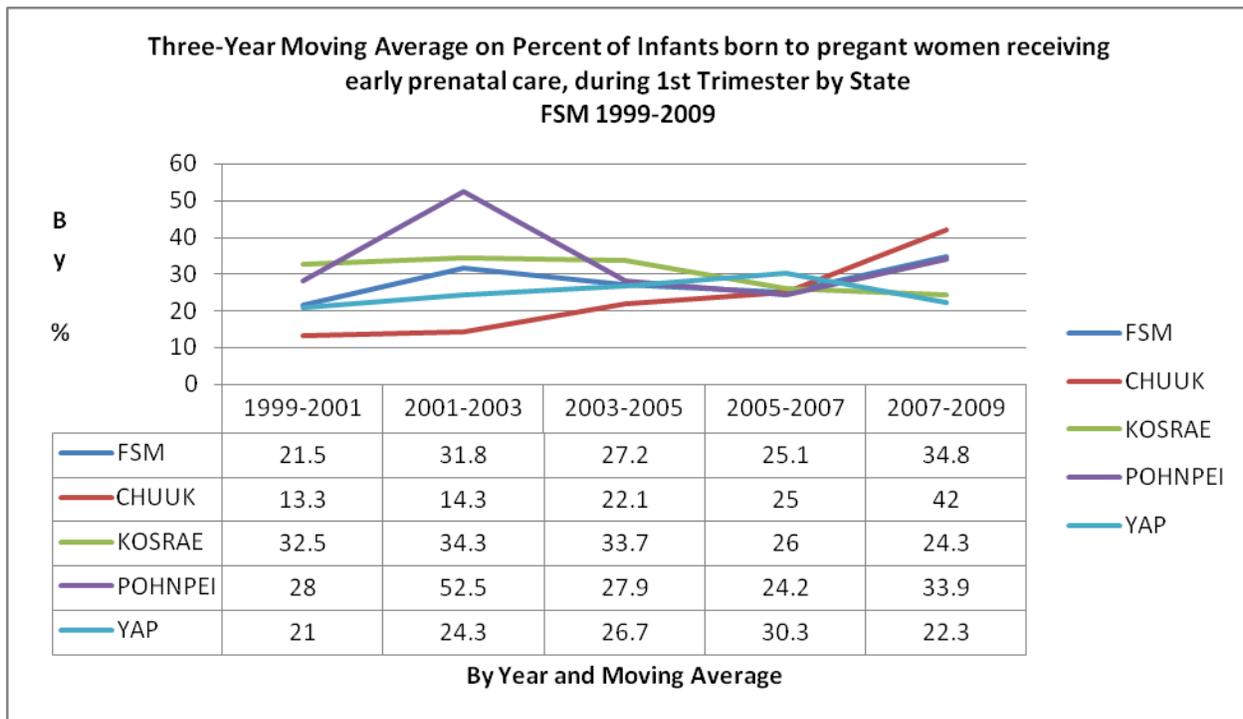
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Core Performances Measures	Pyramid Level of Services				Type of Service		
	DHC	ES	PHS	IB	C	P	RF
1) The percentage of childbearing women in the MCH Program who receive Pap smears.	X				X		
2) Percent of children with identified development problems who are admitted to the CSHCN Program.	X				X		
3) Percent of pregnant women attending prenatal care who are screened for low hemoglobin.		X			X		
4) Percent of infants who receive at least six bottles (1bottle/30 days) of fluoride in the first year of life.		X					X
5) Percent of children with special health needs who have completed reevaluation by the CSN team within the last 12 months.			X				X
6) Percent of women of child-bearing age who attended comprehensive health education workshops in the schools and communities.			X				X
7) The rate of maternal deaths in the reporting year will be decreased.			X				X
8) Percent of one year old babies with anemia.			X				X

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9) Percent of children (5-21 years) diagnosed with Rheumatic Fever.			X				X
10) Percent of child-bearing women with anemia (<35hct).				X	X		

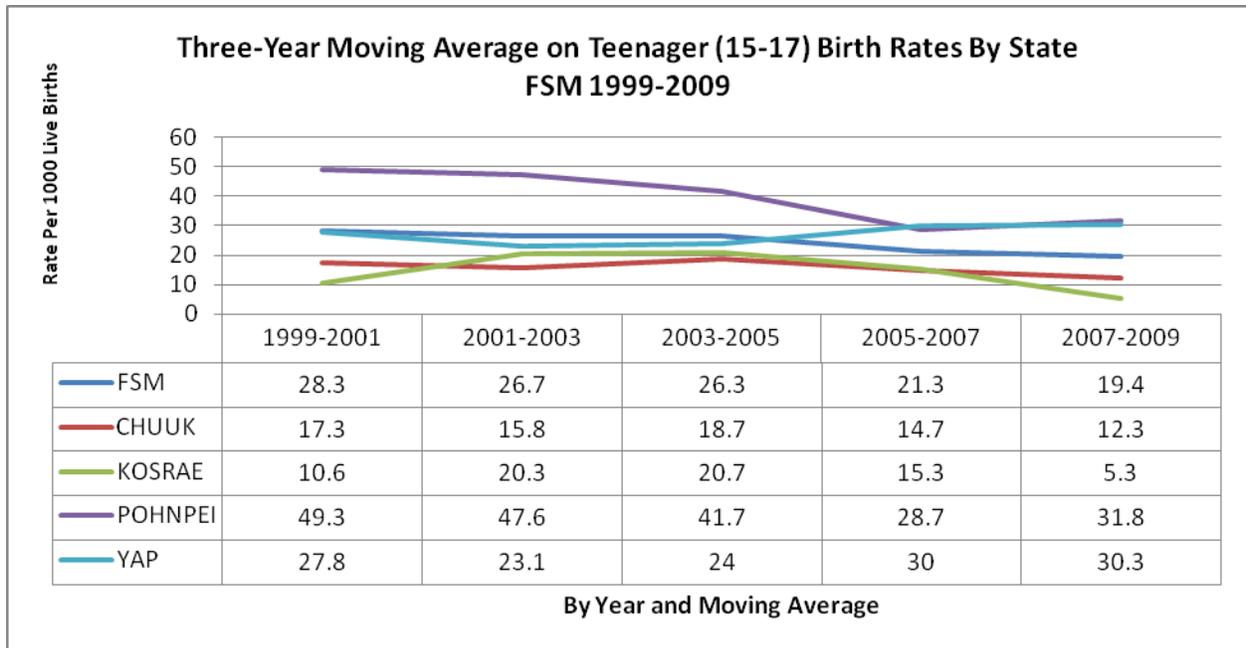
DIRECT HEALTH CARE SERVICES - Pregnant women and mothers: The MCH Program in all four states provides prenatal care services for pregnant women, post-partum care and family planning services for women, and well baby care services for infants. In assessing the National Performance Indicator for women who receive care in the first trimester, 34.7% of the women received early care in 2009, which is much less than the targeted objective of 80%. The three-year running averages from 2005 to 2009 shows an increasing trend from 25% in the 2005-07 period to 29.8% in the 2006-08 period, and 34.8% in the 2007-09. However, this is still low and the trends is still remain with no significant increase at least for the past four years. The increase in early prenatal care is a reflection of the efforts of the MCH programs in defining this issue as



a priority and providing health education to women and conducting outreach services in the communities. National Performance Measure #8, which measures teen pregnancies show that

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21.6 /1000 teen females had a pregnancy which is lower than the targeted objective of 40/1000 teens. In assessing the three-year running averages, there appears to be a slight declining trend in teen births in that the three year average for 2006-08 was 17.9/1000 LB to teen mother, a slight decrease from 21.3/1000 during 2005-07, and slightly went up to 19.3 in 2007-09 period. By individual states, Pohnpei State teen birth is higher with 43/1000. This increase may be associated with Pohnpei’s culture of allowing young men and women to get married at an early age. See table below.



Source: FSM DHSA, MCH Program

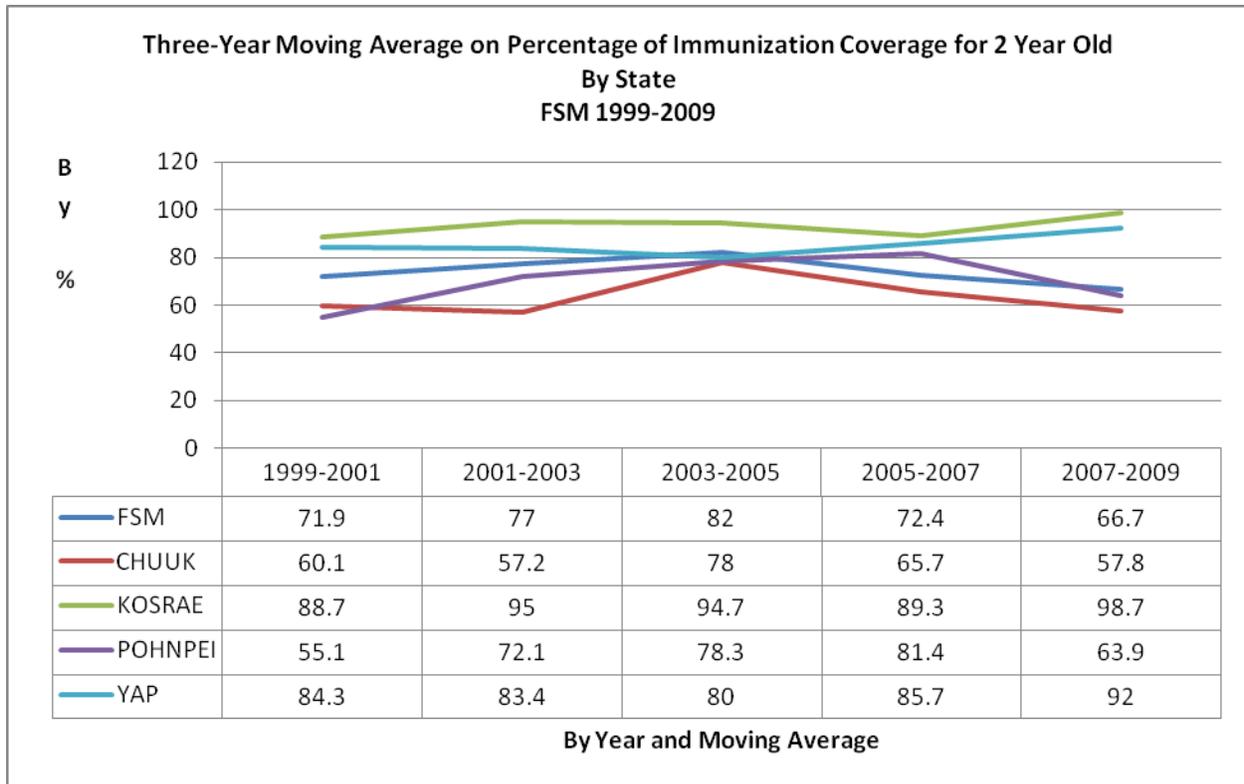
The MCH programs report that there have been an increase in the number of educational sessions on the prevention of teenage pregnancies to youth groups in the community and an increase in outreach to provide health care and preventive education to students in the high schools and community colleges.

Prenatal care services include assessing women for high risk status to determine the level of services that is appropriate for them. All women are screened for cervical cancer with a Pap smear, anemia, STD, Hepatitis B, and risk for gestational diabetes. For the Year 2009, a total of 2205 pregnant women received prenatal care services of which 36.2% received Pap smear screening, 92.8% were screened for Hepatitis B, and 98.7% were screened for anemia. At each clinic visit, weight and blood pressure monitoring is provided. Nutrition education services are provided at both the prenatal clinics and well baby care clinics. During the Year 2009, of the total 2205 women in the states of Chuuk, Pohnpei, Kosrae, and Yap who received prenatal care services all 100% are reported to have at least one nutritional counseling and education session.

Infants and children: The MCH Program in all four states provides newborn and well baby care services, immunization services, school health services, and some preventive dental services. Depending on the state, newborn services are initiated between two weeks and one month of age and is the first well baby care visit for the infant. During the previous years, the Well Baby Program was re-designed to include an emphasis on anticipatory guidance and preventive education. Policy and procedures were established and training of the MCH staff was provided on the implementation of the procedures. The components of the clinic includes: Parent interview, growth measurements, immunizations, developmental screening, hematocrit screening, education and counseling, and physical examination. With the stabilization of the MCH Coordinator and staff at the state levels during the Year 2007, some progress has been made in implementing the policy and procedures for the comprehensive well baby care program.

In assessing the status of completed immunizations among the 2 year old children, in the Year 2009, 67.8% were reported to have been fully immunized which is below the targeted objective of 90%. In assessing the three-year running averages, for the period from 2005-2007, 72.4% of the children were fully immunized, with an increase to 66% for the period 2006-08, but then decreased to 60.6% in 2007-2009. The cause of the decrease in 2009 was due to transportation problem; outreach team was not able to visit the communities as much as they would like to.

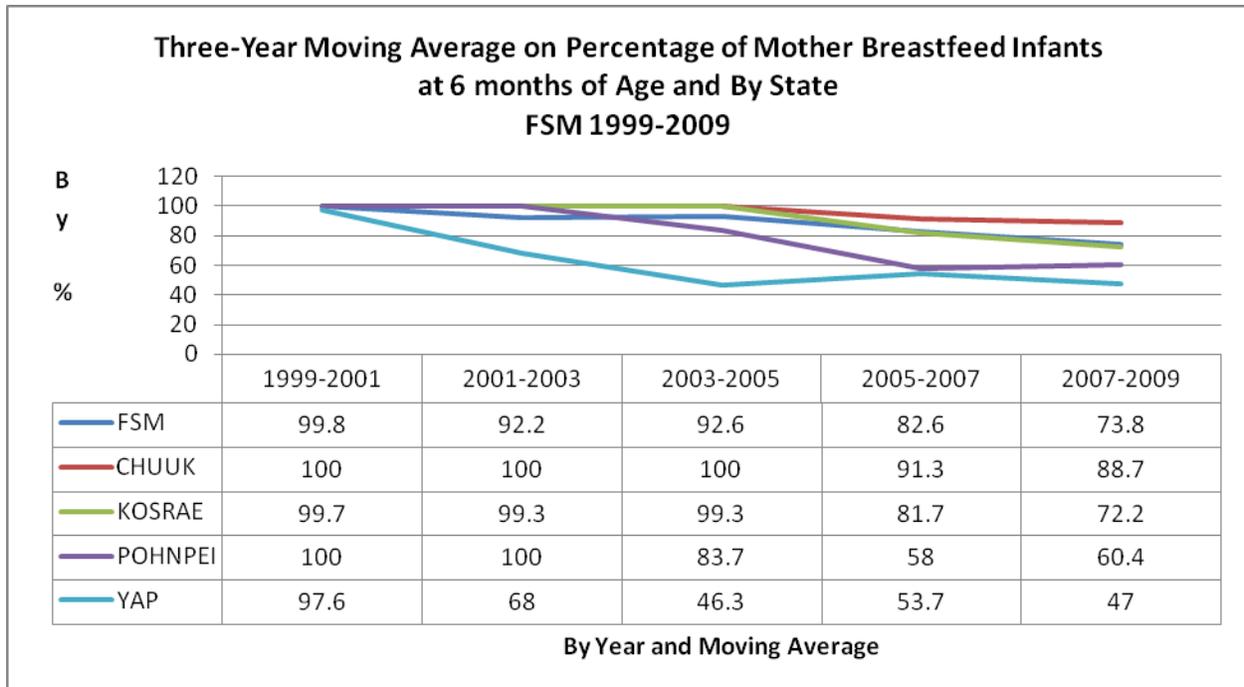
FSM MCH Program – Shaping the Next Generation



Source: FSM DHSA, MCH Program

Efforts have been continued to improve immunization coverage. Well baby clinic services were provided in the four states and of the caretakers who attended well baby clinic 100% of them were provided with at least one nutritional counseling session. The other direct health care National Performance measure was for the monitoring of the 6 month old infants who were exclusively breastfed. The importance of this measure is because of the W.H.O. Baby Friendly Hospital Initiative, which recommends exclusive breastfeeding of infants at discharge and for the first six months of life. Under this initiative, exclusive breastfeeding is defined as breast milk only with no water, no coconut juice or water, no juice, no solid foods for the first six month. Since 2005, the percent of infants who were breastfed at 6 months old have fluctuated from 100% in 2005 to 73% in 2006, 74.9% in 2007, 73.2% in 2008, and 73.8% in 2009. This is far lower than the 2009 performance objective of 90%.

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Source: FSM DHSA, MCH Program

Despite these fluctuations there has been a definite trend of an increasing proportion of infants who are being breastfed in the FSM. In assessing the three year running averages, 82.6% of 6 month old infants were breastfed for the period 2005-07, with a decrease to 73.7% in 2006-08 and increased to 73.8% in the 2007-09 period.

Children with special health care needs: The MCH Program in all four states has developed a Children with Special Needs Program and continues to provide a special clinic and follow-up services for children with special needs. This program is a collaborative interagency effort among the MCH Program, the Special Education Program, the Early Childhood Education (ECE) Program, the state hospital, and community nutrition programs. The professional staffs that are included as part of the interagency team include the CSHN Coordinator (Public Health Nurse), a physician from the hospital, the physical therapist (where one is available), Related Services Assistants (RSA) from the Special Education Program, and the Disabilities Coordinator from the ECE Program. Children who are suspected of having a handicapping condition are referred to the CSHN Assessment Clinic where a comprehensive assessment is provided, intervention services are recommended and follow up services are provided by the CSHN Coordinator or the RSA. Referrals for specialty clinics and specialty services are made through the CSHN clinic. As of 2009, there are a total of 1,251 children registered in the four state CSHN Programs.

The following National Core Performance Measures (#1 - #2) and State Negotiated

Performance Measures (SP#2 and SP#9) are related to the Direct Health Care Services level of the MCH Pyramid.

National Core Performance Measure #1 - Not applicable for the FSM

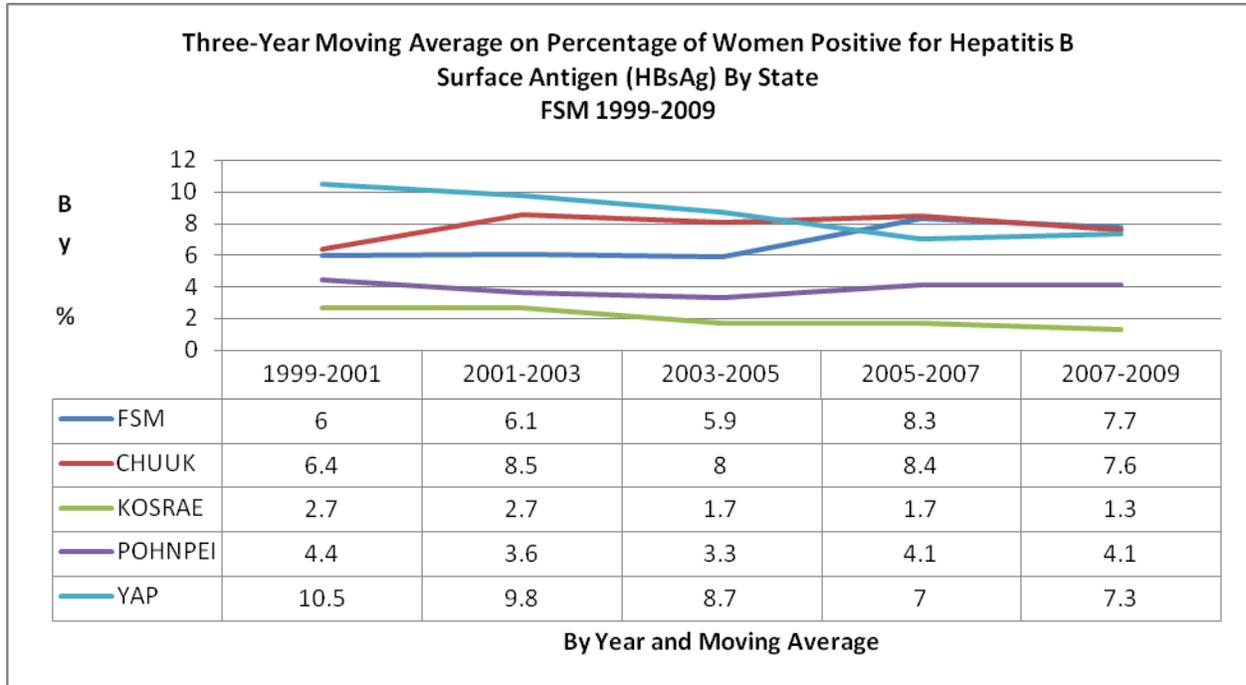
National Core Performance Measure #2 - The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. *Annual Performance Objective for 2011 = 95%.*

The Annual Performance Indicator for FSM for 2009 is 48.3%, which is much lower than the performance indicator for the year. Of the nine possible specialty and sub-specialty services provided by the CSHCN programs, all states provide medical and limited surgical sub-specialty services by referral, PT services home, health care services, nutrition services, care coordination and early intervention. Because of the limited resources, there does not appear to be any opportunities of increasing the array of specialty and subspecialty services for children with special needs.

State Negotiated Performance Measure SP#2 – The percent of women who have screened for Hepatitis B surface antigen (Replaced in 2011).

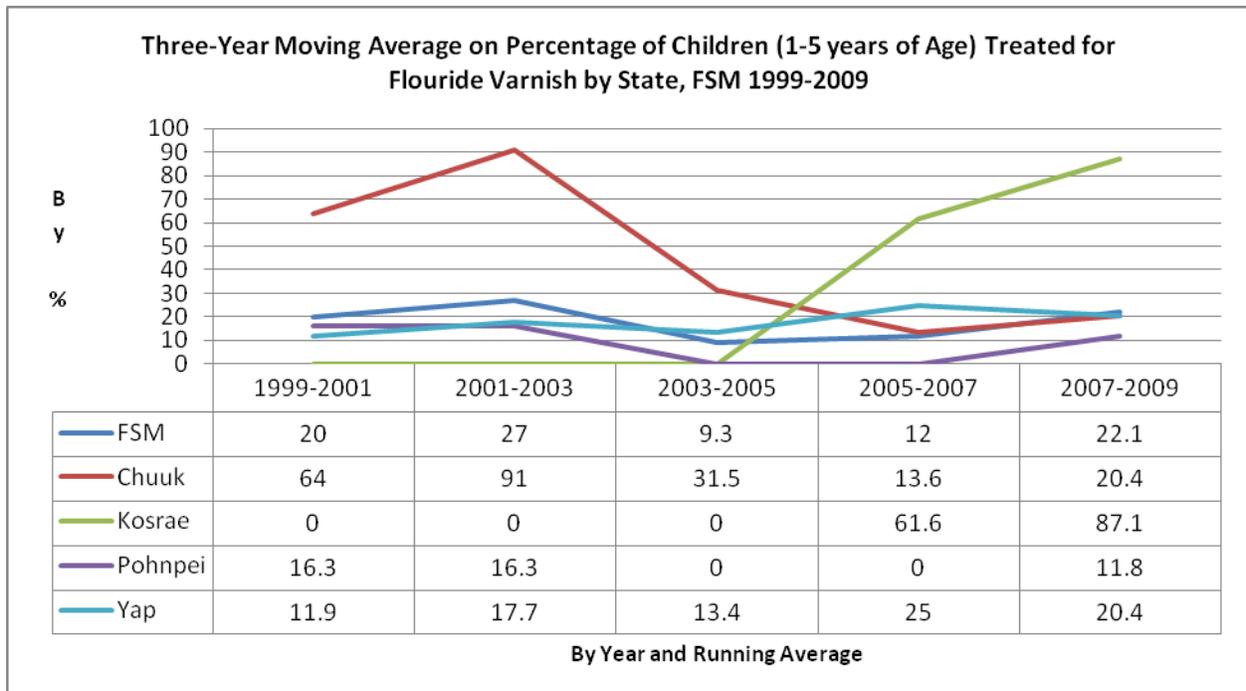
The Annual Performance Indicator for FSM for 2009 is 92.8%, which is higher than the Performance Objective for the year. In assessing the data for the individual states for 2009, Yap state had the highest percentage of women with positive Hepatitis B at 11.6% followed by Chuuk (6.8%) and Pohnpei (4.4). Kosrae has the lowest percentage of women with hepatitis B at 1%. In assessing the trends from 2005-2009, FSM is showing a declining trend. During the period 2005-2007, 8.2% of women were screened with positive hepatitis B and the same percentage was reported for the period 2006-2008. The percent of women with positive hepatitis B decreased to 7.7% during the period 2007-2009. One of the major reasons for the higher rate in Yap is because of the fact that the CHCs were also doing screening, which increase the number of women screened in 2009. The importance of detecting hepatitis B in pregnant women early is very important so proper education, counseling, and treatment can be provide to the safeguard the lives of the woman and infant.

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Source: FSM DHSA, MCH Program

State Negotiated Performance Measure SP#9 - Percent of children 1-5 years old who treated for fluoride varnish. *Annual Performance Objective for 2011= 80%.*



Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM for 2009 is 18.8% which is much lower than the targeted objective for the year. The purpose of the decrease was due to unavailability of supplies. During 2009, Kosrae State reported the highest percentage of 1-5 year olds treated with fluoride varnish at 88.2%, followed by Chuuk and Yap States. Pohnpei reported the lowest at 6.4%. Pohnpei State reported lack of fluoride varnish as the major cause for the low coverage. Although, there were fluctuation by State coverage between 2005 and 2008, overall, FSM is showing an increasing trend for treatment of fluoride varnish.

ENABLING SERVICES - *Pregnant women and mothers:* As part of the prenatal care services, health education services are provided to all women who attend the prenatal care program. These health education sessions include nutrition, diet, healthy pregnancies. For pregnant women who live in the remote outlying areas that are not accessible to the public health and hospital based services, outreach services are provided by the Health Assistants in the dispensaries. In Yap state, Chuuk state, and Pohnpei state, health teams are deployed on ships to travel to the outer islands where prenatal care is provided to pregnant women living on these remote islands. Those women who are identified as high risk are brought to the main island where they continue their prenatal care at the Public Health prenatal care clinic or at the State Hospital. For women who have delivered and who attend the post-partum clinic, family planning education and counseling are provided with referrals to the Family Planning Clinic for those women who choose a contraceptive method.

Infants and children: In Chuuk, Pohnpei, and Yap states, the MCH Program provides outreach services in remote rural villages to provide immunization, dental services and weight monitoring services. The MCH Program provides transportation by ship or by vehicle for a public health team of professionals to travel into communities to provide immunization, screening services and health education services.

Children with special health care needs: As part of the Children with Special Needs program, transportation services to the CSHN Assessment clinics were provided by the Special Education program. For those children who lived in the rural areas and did not have transportation or have difficulty in being transported to the clinic site, home visits by the SSDI Consultant, the interagency team of CSHN Coordinator, and the Special Education staff of Related Services Assistants were provided where an assessment was conducted and recommendations were made to the parents. Case management and follow up services were provided to all children who are in the CSHN program.

The following National Core Performance Measure (#3) and the State Negotiated Performance Measure (#10) are related to the Enabling Services level of the MCH Pyramid.

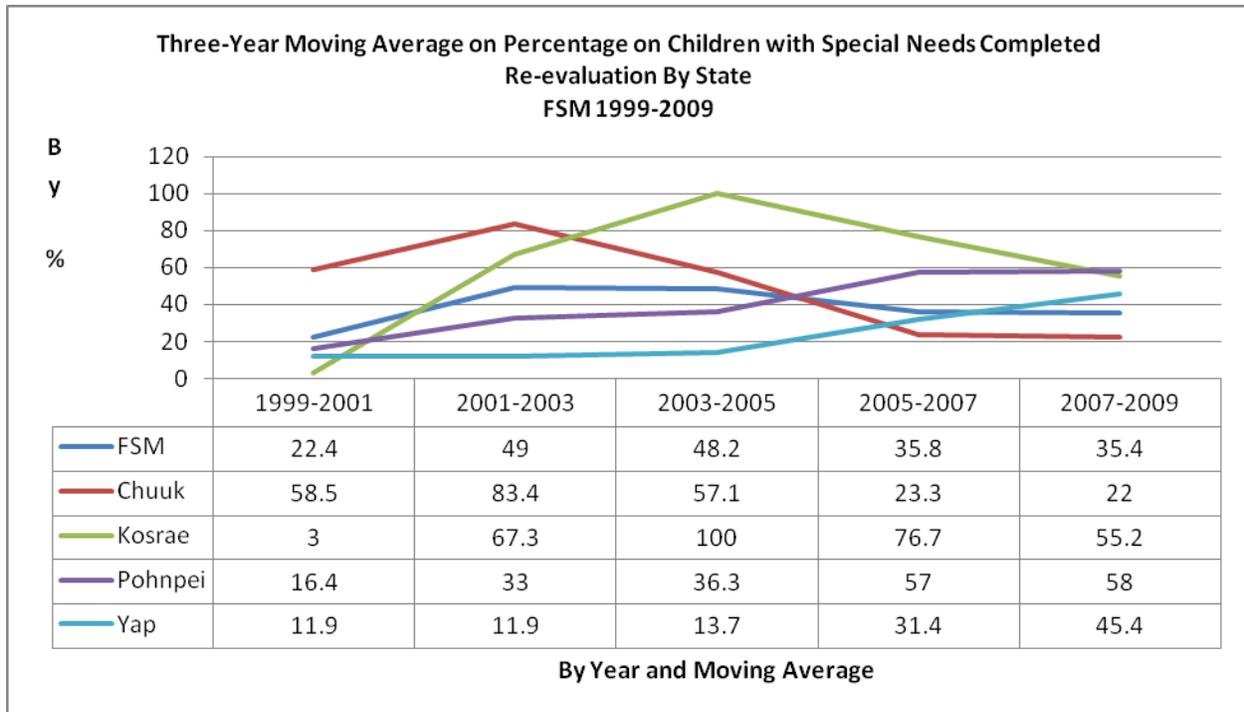
National Core Performance Measure #3 - The percent of Children with Special Health

Care Needs (CSHCN) in the State who have a “medical/health home.” *Annual Performance Objective for 2011=90%*

The Annual Performance Indicator for FSM is always at 100% over the years, and this was based on our understanding of the definition of a “medical home”. In 2009, the Annual Performance Indicator for the FSM was 79.2%, which is lower than the targeted objective for the year. Because of the unique situation in all four FSM states, all medical and health care services are provided by or paid for by each State Hospital and the programs in the Primary Health Care Services Division. When a child is referred and accepted in the CSHN Program, the CSHN Physician becomes the primary physician. In addition, because of the close working relationship between the CSHN Program and the MCH Program, all preventive health care services provided to well babies and children are also provided to all children with special needs. The CSHN Coordinator becomes the primary coordinator for each of the children in the program and coordinates all of the medical and health services. Therefore, we assumed that every child in the CSHN Program has a medical/health home. However, at the 3rd FSM Early Childhood Special Education and Maternal and Child Health, a joint Workshops May 18, 2004, there was a presentation on the “Medical Home” concept where we realized that “medical home” is more than just the hospitals, primary health clinics and other health and medical related agencies. Therefore, the MCH and CSHN staffs felt and realized that 79.2% may be more realistic than the 100%.

State Negotiated Performance Measure SP#10 - Percent of children with special health needs who have a completed re-evaluation by the CSHN Team within the last 12 months. *Annual Performance Objective for 2004=65%*

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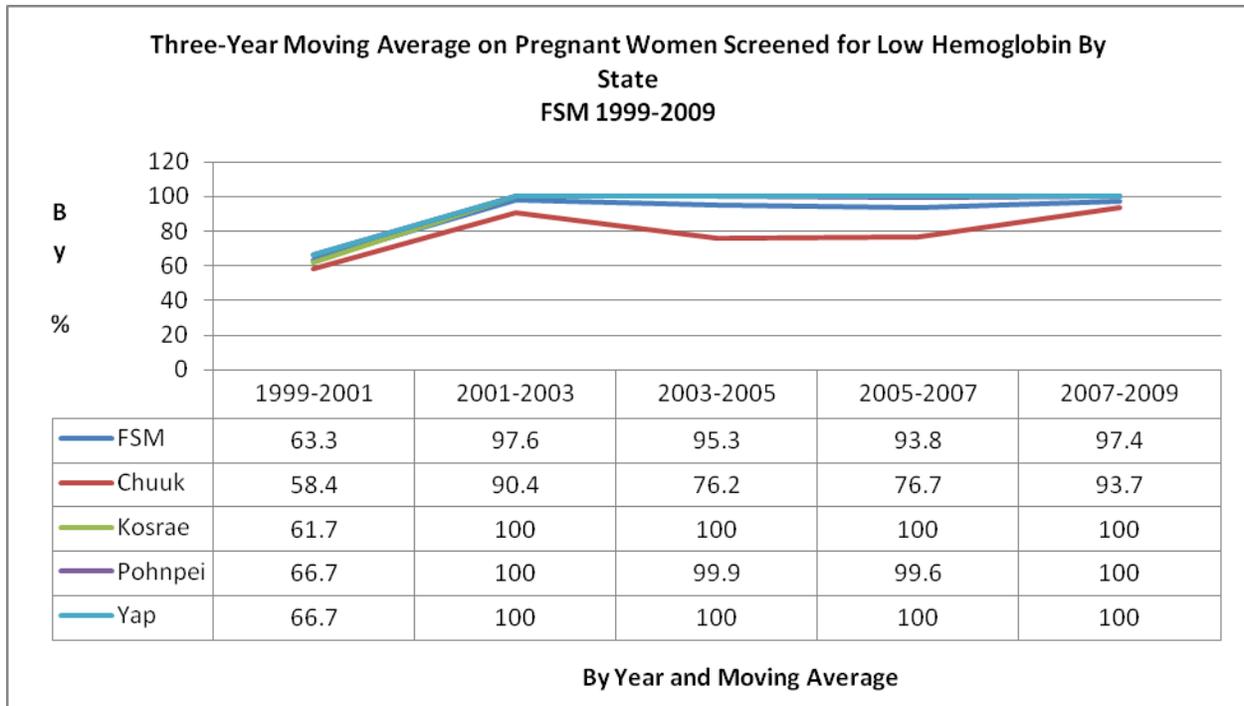


Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM for 2009 is 35.8%, which is lower than the target objective of 65%. It was reported that the State Interagency teams in the four States became inactive, which may have contributed to the decrease. The assessment of the data from 2005 to 2009 showed that the percent of children with special needs has been slightly decreasing over the years. For the period 2005-2007, based on a 3 Year Average, FSM reported 35.8% but decreased slightly to 35.5% between 2006-2008 and to 35.4% between 2007-2009. Of the 1251 children registered in the CSHN data base for the four states, 448 were identified as having received a re-evaluation within the last 12 months. Because of the high level of performance for the past three years, the performance objective for the years to come, 2010 and 2011 will need to increase to meet the target objective.

POPULATION-BASED SERVICES - Pregnant women and mothers: The population-based services for pregnant women are provided through the prenatal care clinic. These services include screening for anemia, screening for Hepatitis B surface antigen, STD screening, nutrition education and counseling, breastfeeding education and counseling. During the Year 2009, there were 2,205 women who received prenatal care services in the four states and of these, 34.7% received care in the first trimester. During prenatal care program, women receive a Pap smear screen and are screened for anemia and Hepatitis B. During the Year 2009, 36.2% of the women received a Pap smear of which 2.9% were positive. This compares with 40% of the women who received a Pap smear in 2008 and 1.9% were positive.

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Source: FSM DHSA, MCH Program

The variability in the proportion of women receiving Pap smears is due to the fact that the supply of Pap packs is not consistent and some of the states are without Pap smear kits for several months during the year.

During 2009, of the pregnant women in the prenatal clinics, 98.7% of the women were screened for low hemoglobin which is an increase over the 94.9% for 2008 and 98.6% for 2007. Of the total screened, 26.6% were positive, a decrease from 42.5% in 2008.

Infants and children: The MCH Programs in the four states provide services through the well baby care clinics. Population-based services for infants included developmental screening, growth monitoring, immunization, and providing fluoride supplements. For older children, services include dental sealants on at least one molar tooth. The percent of 1-5 years who received fluoride varnish has been fluctuating between 2005 and 2009. However, when doing a 3 Year Average it shows that the number of 1-5 year olds who were treated with fluoride varnish was increasing. One of the problems with the provision of dental care is that the MCH Program is dependant on the Dental Divisions for personnel to provide the services; often the objectives of the programs are not consistent and the objectives of the MCH Program are not a priority and personnel are not available to provide the preventive services.

Children with special health care needs: Since services for children with special needs are individualized, specific targeted population-based services were not provided to these

children. Because of the close association between the CSHN Program and the MCH Program in the four FSM states, these children were included in the population-based services provided to all children through the MCH Program's well baby care services.

The following National Core Performance Measures (#4, #5, #6, #7, #8, #9, and #10) and State Negotiated Performance Measures (SP#1, #2, #4, #5, #7, #8, and #10) are related to the Population-Based Services level in the pyramid.

National Core Performance Measure #4 – The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

National Core Performance Measure #5 – The percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

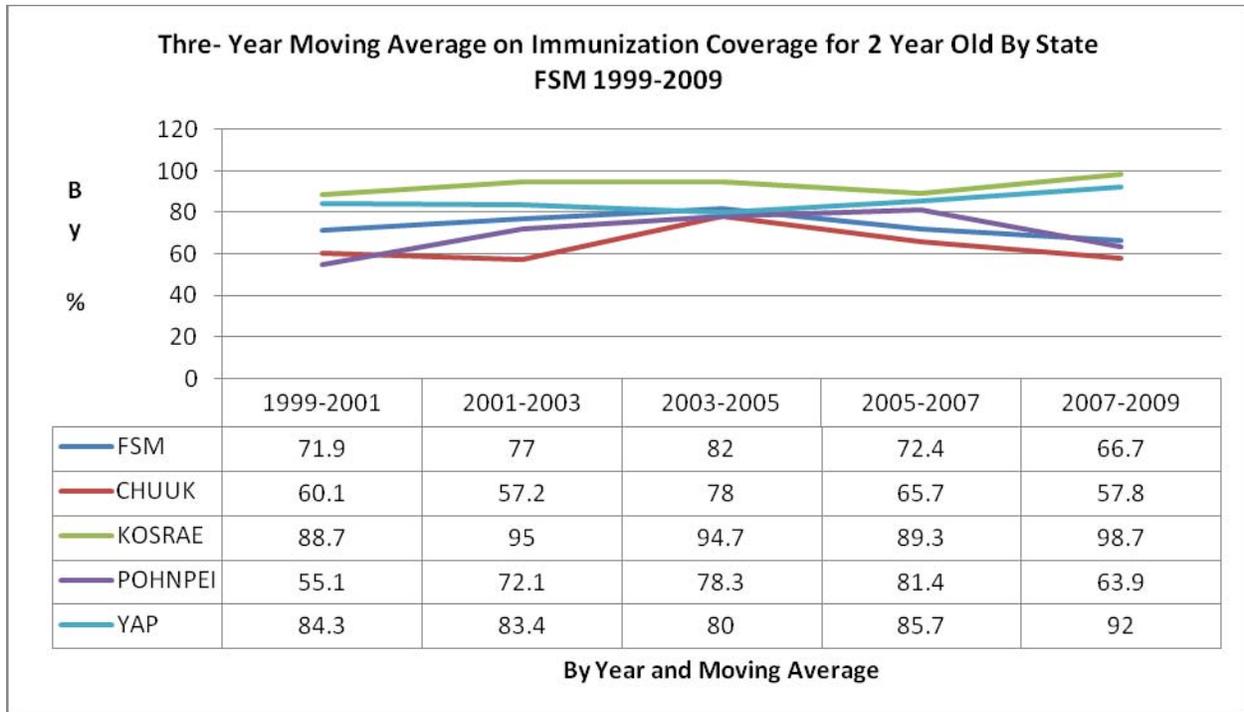
National Core Performance Measure #6 – The percent of youth with special health care needs who receive the necessary to make transition to all aspects of adult life.

National Core Performance Measure #7 - Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. *Annual Performance Objective for 2004=80%.*

The Annual Performance Indicator for FSM for 2009 is 67.8%, which is steadily increased from 63.4% in 2008.

In assessing the data for three-year running averages, the proportion of fully immunized children was 72% in 2005-07, but decreased to 66% in 2006-08, and increased to 66.6% in 2007-09. When the data for the four states are assessed separately, it showed that Chuuk and Kosrae States are improving, Pohnpei is not improving and Yap was steady in the low 90%.

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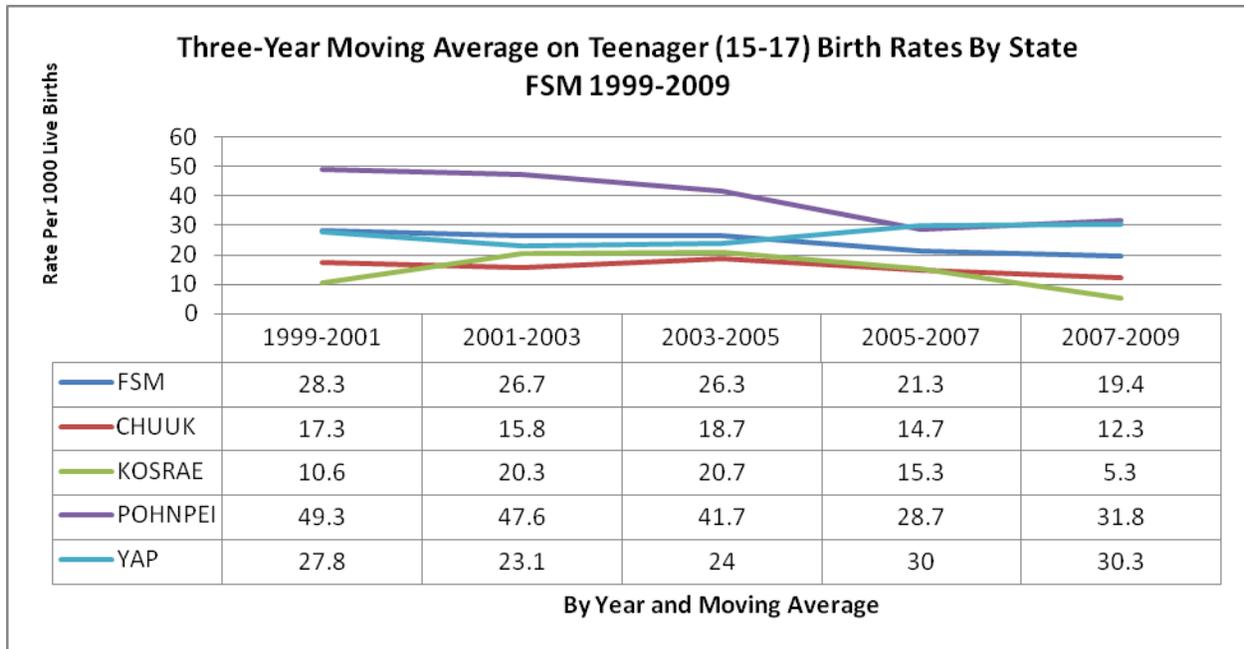


Source: FSM DHSA, MCH Program

The declined in Pohnpei immunization rate was due to several events affecting Pohnpei State; 1) broken down of the Ms. Micro-Glory (old field trip ship to go out to the outer islands, (2) lack of proper planning and disorganization, and the (3) discrepancy between the documentation of immunizations given on the immunization cards and the central immunization data base. The success of Chuuk and Kosrae States was because immunization of children is one of the major efforts of the MCH Program where immunizations are not only given during well baby clinics, but outreach services for immunizations to the communities are provided routine

National Core Performance Measure #8 - The birth rate (per 1,000) for teenagers aged 15 through 17 years. *Annual Performance Objective for 2004=18*

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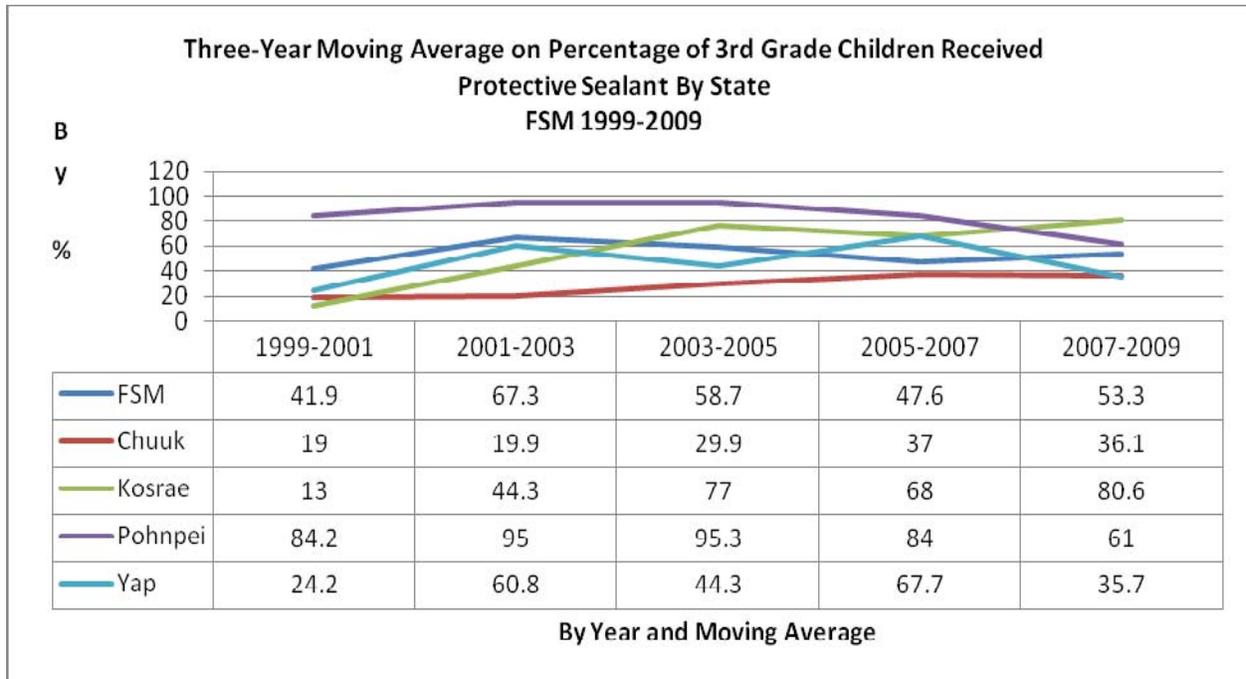


Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM overall for 2009 is 21.6 /1000 females 15-17 years, which is higher than the targeted objective for the year of 40/1000 teens. In assessing the three year running averages for 2005-2009, there is a slight declining trend in the time period 2006-2008, the rate was 17.9/1000 a decreases from 21.3/1000 for 2005-07, but slightly increased to 19.3/1000 during period 2007-2009. Examination of the year 2009 data for the four states reveal that Pohnpei state recorded the highest rate at 43/1000, followed by Yap at 37/1000, and Chuuk at 14/1000. One of the reasons for these high rates may be because of the cultural factors where many of the young women in Micronesia at 17 years of age are married and starting their families. Another reason may be because of the stigma of having a child at a young age is not as prevalent as in the mainland US. In Micronesia, where living in extended families is the cultural norm, when infants are born to young mothers, the maternal grandparents and other relatives assist the young mother in raising the child. Despite, these cultural values, it is still common for young women with infants to drop out of school and for this reason, the prevention of teen births will need to continue to be a focus of the MCH Program.

National Core Performance Measure #9 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth. *Annual Performance Objective for 2011=80%*

FSM MCH Program – Shaping the Next Generation

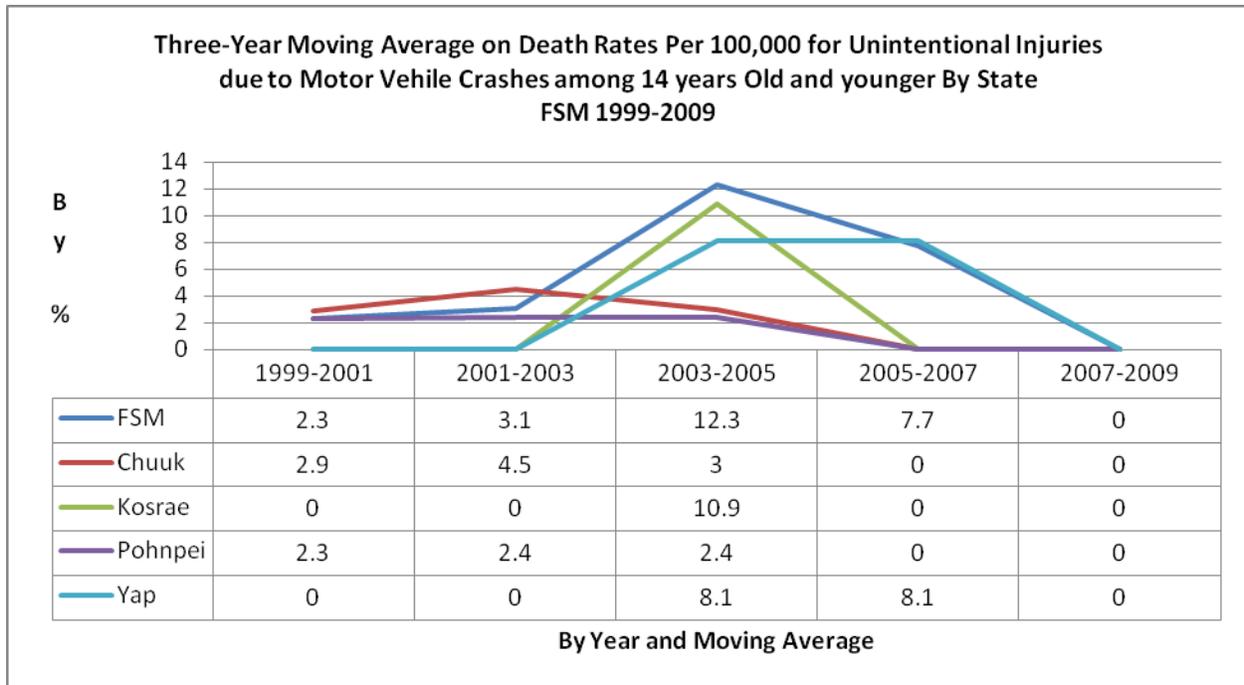


Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM for 2009 is 56.2% which is below the targeted objective for the year of 75%. The MCH Programs in the four states have been working in collaboration with the state Dental Services Division for the past several years to achieve this performance measure. In 2009, 56.2% received dental sealant, an increased from 39.7% in 2008, 37.6% in 2006 and 40.7% in 2005. The 3 Year average shown steadily increase from 47.2% for the period 2006-08 to 53.4% for the period 2007-09. In assessing the 2009 data for each state, there is tremendous variability in that Chuuk reported 25.2% of the third grader children received a dental sealant, 12% in Yap, 93.7% in Kosrae, and 91.7% in Pohnpei. The MCH Program has purchased dental sealants and provided them to the dental staff who applied the sealants. In addition, the MCH Program also purchased some portable dental equipment so that dental personnel were able to go into the schools to provide these services. The MCH Program is dependant on the dental staff to provide the services and often the staff is not available. The MCH Coordinators have reported that few school visits were conducted during 2009 because of the lack of time for the dental staff.

National Core Performance Measure #10 - The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. *Annual Performance Objective for 2011=3/100000 children age 14 and younger.*

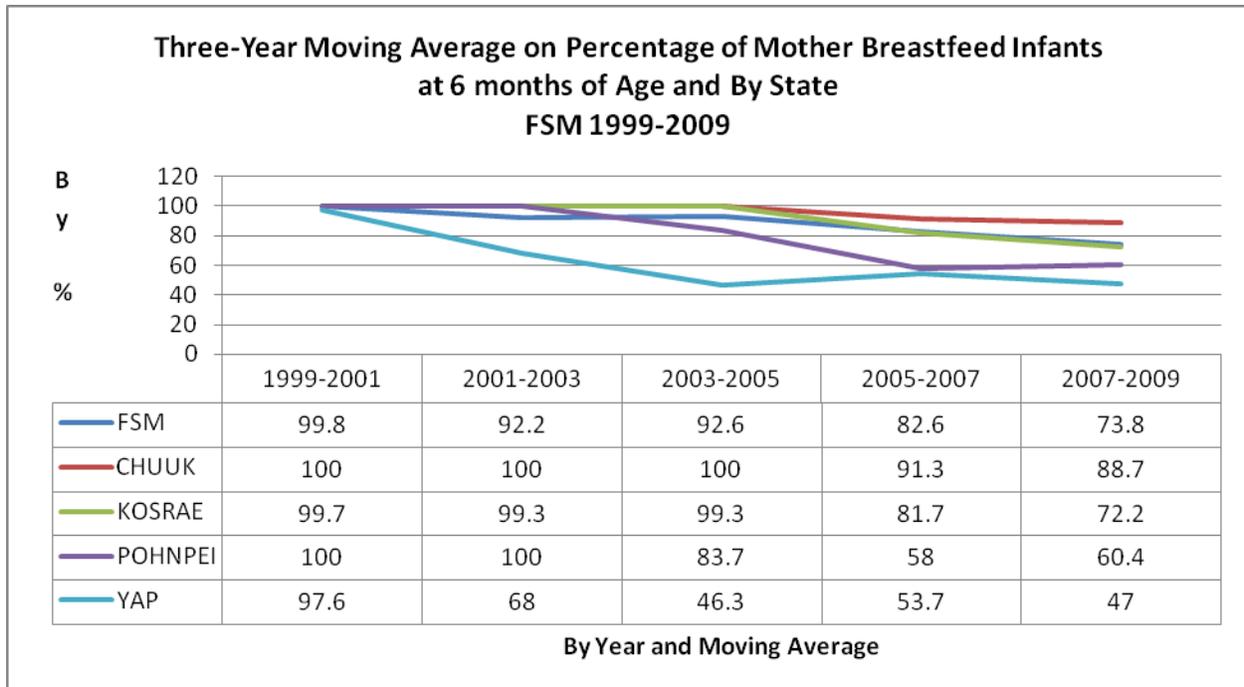
FSM MCH Program – Shaping the Next Generation



Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM for 2009 is 0/100,000. The performance objective for 2009 was 5/100000 children 1-14 years of age. In 2009, all of the FSM States reported “0” or no children 14 years and young died caused by motor vehicle crashes.

National Core Performance Measure #11 - Percentage of mothers who breastfeed their infants at hospital discharge. *Annual Performance Objective for 2011=95%.*



Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM for 2009 is 73.4% which is below the targeted objective for the year. Three of the four hospitals in the FSM (Chuuk , Pohnpei, and Kosrae) adopted the Baby Friendly Hospital concepts and put forward the policy, and Yap just started. This consistently high percentage of mothers who are discharged from the hospital while breastfeeding is due to the fact that bottle formula are not allowed in any of the hospitals in the FSM unless ordered by the physician for medical reasons; all mothers are encouraged and supported to breastfeed their infants while in the hospital; and mothers are not discharged from the hospital until the infant is breastfeeding with no difficulties.

National Core Performance Measure #12 – Percent of newborns who have been screened for hearing before hospital discharge. *Annual Performance Objective for 2011 = 100%*

The Annual Performance Indicator for FSM for 2009 is 46% which is below the targeted objective for the year.

In 2008, FSM was funded by HRSA, through the Universal Newborn Hearing Screening and Intervention (UNHSI) program to do newborn screening at the four States Hospitals in the FSM. Equipments were purchased and screeners were trained and Newborn hearing screening before hospital discharge is on-going in all of the FSM States. In 2009 out of the 2,157 live births 1,006 children reported having hearing screening before hospital discharge. Chuuk reported 387 screened out of 858 children, Kosrae reported 104 screened out of 175, Pohnpei reported 433 screened out of 891, and Yap reported 82 screened out of 233 children.

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State Negotiated Performance Measure SP#1 - The percent of women receiving services in the MCH Programs who receive a Pap smear. *Annual Performance Objective for 2011= 100%.*

The Annual Performance Indicator for FSM for 2009 is 36.2% is still lower than the targeted objective for the year.

During the Year 2009, a total of 3039 women received services in the MCH Programs (prenatal, post-partum, and family planning) of which 1121 (36.2%) received a Pap smear. In assessing the data from the four states for the Year 2009, the State of Chuuk provided Pap smear screening for 28% (270 of the 966 women) of the women; in Kosrae, 241 of 356 (67.7%) women were screened with a Pap smear; in Pohnpei 149 out of 989 women (15.1%) and in Yap 461 out of 782 (59%) of the women received Pap smears. More important is assessing the proportion of the screened women with positive Pap smear screening results. In the year 2009, 5 (3.4%) out of the 149 women in Pohnpei have positive Pap smear. 13 (5.4%) out of 241 women in Kosrae were positive, and 14 (3%) out of the 461 women screened in Yap were positive. Chuuk reported that out of the 270 women who received a Pap smear “0” or no positives. Women with positive Pap smears are referred to the medical staff at the state hospital for intervention and treatment.

State Negotiated Performance Measure SP#2 - Percent of pregnant women who have been screened for Hepatitis B surface antigen. (Replaced in 2011)

The Annual Performance Indicator for FSM for 2009 is 92.8%, which is higher than the targeted performance objective for 2009.

The percentage of women screened varied among the four states: this year, Chuuk screened 84% of the pregnant women who attended the MCH clinics, which is significant dropped from 100% in 2008. Kosrae, Pohnpei and Yap States screened 100% of all women attended the MCH clinics. The possible reasons for these fluctuations have been economic and changing and relocation of manpower and offices. The bottom line is disorganization of which is now being discussed and shared with stakeholders and the appropriate leaderships for supports which have been positives and confidence for the year to come. In examining the 2009 data for positive Hepatitis B status, Yap state reported the highest number of women with positive Hepatitis B screening with 11.6% of the women screened being positive; followed by Chuuk with 6.8% positive, Pohnpei with 4.4% positive, and Kosrae with 1% of the women screening with a positive test.

State Performance Measure SP#8 - Percent pregnant women attending prenatal care who are screened for low hemoglobin. *Annual Performance Objective for 2011= 100%*

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The Annual Performance Indicator for FSM for 2009 is 98.7% which is slightly lower than the targeted objective for the year.

It reflects the fact that hemoglobin screening is routinely performed at the first prenatal care visit no matter when that first visit occurs. In assessing the percent of women screened by the states for 2009, Kosrae, Pohnpei and Yap states are all screening 100% of the women who attend prenatal care services; whereas Chuuk state screens 97% of the women in the prenatal clinic. The performance measure is largely dependent on the availability of the laboratory

	FSM	Chuuk	Kosrae	Pohnpei	Yap
Percent Positive Pap Smear					
2008	1.9	0	5	0	5
2009	2.9	0	5.4	3.4	3
Percent Positive Hepatitis B					
2008	6.6	10	1	4.2	6
2009	5.8	6.8	1	4.4	11.6
Percent Low Hemoglobin					
2008	42.5	61	23	41.4	20.6
2009	26.6	23.2	48.2	26.4	22.3

supplies to measure the hematocrit or hemoglobin and is the reason for Chuuk's lower performance measure. The most pleasing aspect of the data is that the proportion of pregnant women in the FSM who attend the prenatal clinic with low hemoglobin has decreased from about 43% in 2008 to about 27% in 2009. Of the pregnant women who were screened in 2009, the pregnant women in Kosrae have the highest proportion with anemia in that 48.2% of the women screened have low hemoglobin that required iron therapy, followed by Pohnpei which has 26.4% of

Percent Positive Prenatal Screening Tests

the women with anemia, Yap state with 22.3% and Chuuk with 26.6% of the women reported to have low hemoglobin results. These data becomes even more concerning when viewed in the light of the fact that there is an increasing prevalence of Vitamin A Deficiency among young children, increasing anemia rates among young children, and lead poisoning among children. It appears as if the health status of the most vulnerable of the population - mothers and children - is being compromised because of a pervasive and overwhelming status of poor nutrition. The MCH Program must develop and implement an aggressive nutrition education and food supplement program to assure that the nutrition of the mothers, infants, and children in the FSM is improved.

State Performance Measure SP#9 - Percent infants Children 1-5 year old who treated for fluoride varnish. *Annual Performance Objective for 2011= 85%*

The Annual Performance Indicator for FSM for 2009 is 18.8%. It is below the performance objective for the year. Most of the FSM States have difficulties with supplies and in coordinating with Dental clinics on proper recording and reporting on this performance objective. Kosrae reported the highest with 88.2% followed by Chuuk at 18.3% and followed by Yap at 12.2%. Pohnpei reported the lowest at 6.4%. The collecting of data continues to be a problem in all of the four states coupled with the fact that some of the states were depleted of their supply of fluoride supplement during the year.

During the 2010 MCH Need Assessment Survey, a list of MCH Needs ranked and the problem of Dental Caries was ranked the 3rd priority for FSM. The evidence of the dental caries

was cleared and with strong recommendation by the stakeholders. Therefore, prior years obstacles need to be resolved with the supports of the stakeholders and or the women NGOs, for example: the question and issue on the inconsistency and in-compliance of actually taking the supplement, the lack of education on overall oral hygiene, the effectiveness of this activity and the impact of the program in preventing dental caries at the community levels. The MCH Program will continue collaborate and partner with Dental Health programs to develop a more basic and comprehensive oral hygiene education program with the application of fluoride varnish starting in the Well Baby Clinics and extending to the Well Child Clinics and the schools. Policy direction to review dental reports and to be provided to the MCH program by month or quarterly to measure the dental caries program activities and share data with appropriate leaderships.

INFRASTRUCTURE-BUILDING SERVICES - Pregnant women and mothers: The prenatal and post-partum care services are planned, implemented, and evaluated by the Family Planning Coordinators who are funded through the Title X Family Planning Program or the state government. These coordinators work with the MCH Coordinators; however the infrastructure-building services are accomplished by the Family Planning Coordinators. During 2007, the four states developed a policy and procedure manual for prenatal care which is an attempt to standardize the care of pregnant women across the FSM. Training on the implementation of these procedures have been conducted during the on-site consultations and the procedures are being implemented.

Infants and children: In order to assure a consistent standard of care for well baby care, the MCH Programs in the four states developed the comprehensive well baby care program through the efforts of the SSDI Project. The policy and procedure manual was completed and training provided on the implementation of the procedures. In-service training was provided on growth monitoring and developmental screening. The MCH staff in each of the states will decide on the methods of phasing in the well baby care program. However, because of the changes in the MCH Coordinators in three of the states, the implementation of the comprehensive well baby clinic services was delayed and the new MCH Coordinators were re-trained.

Children with special health care needs: During 2009, the CSHN Program continued to develop the CSHN Program and the CSHN Interagency Assessment Clinic through the efforts of the SSDI Project. In June 2009, training was provided to the CSHN Coordinators on the Policy and Procedures Manual, the forms, the data system, and the implementation of the procedures. The data base structure was developed using EPI-INFO and training was provided on data entry and data extraction and analysis. As of the Year 2009, in the four states, there were a total of 1251 children in the CSHN computer data base; of which 448 (35.8%) were reported as having a re-evaluation during the year.

The following National Core Performance Measures (#11, #12, #13, #14, #15, #16, #17,

#18) are related to the Infrastructure Building Services level in the pyramid.

National Core Performance Measure #4 - Percent of Children with Special Health Care Needs (CSHCN) in the state CSHCN Program with a source of insurance for primary and specialty care. *Annual Performance Objective for 2011=80%*

The Annual Performance Indicator for FSM for 2009 is 26%. This is far lower than the performance objective for the year. The FSM is unique in that the State Government provided all medical and health care services through the State Hospitals and the Public Health Division. All of the 1251 children known to the Children with Special Needs Program receive the available health care services provided by the state. Primary care services and Specialty consultants - orthopedics (Shriners Hospital), cardiologist, ophthalmologists - who provide itinerant services in the four states are available to children in the CSHN program. The only health insurance program that is available to the population in the FSM (MICARE) is for employees of the National and State governments and their families. It is important to note that with the difficulties in operating the health facilities, some of the states have been proposing new policy for everyone to pay for their services. In 2009, MICARE Insurance (a Government owned insurance) reported that 5,513 have Insurance, of this total 4,174 are between ages 5-14 years old and 1,339 are 4 years and younger.

National Core Performance Measure #13 - Percent of children without health insurance. *Annual Performance Objective for 2011=7%*

The Annual Performance Indicator for FSM for 2009 is 73.4%. This is much higher than the performance objective for the year. Yap estimated that 5,215 (90%) of the 5810 children do not have health insurance, followed by Kosrae (79.8%) 2884 out of the 3610 children, followed by Chuuk (62%) 16,580 out of 26,756 and Pohnpei (41%) 6,774 out of 16,524 children reported to not have insurance. FSM is unique in that the State Government provided all medical and health care services through the State Hospitals and the Public Health Division. MICARE Insurance, the only health insurance program that is available to the population in the FSM, is for employees of the National and State governments and their families. It is important to note that with the difficulties in operating the health facilities, some of the states have been proposing new policies for everyone to pay for their services. In 2009, there were 5,513 children with insurance through their parents' insurance policies. It is estimated that in 2011 more children will have insurance, because of the demands for quality of services and with payment.

National Core Performance Measure #14 – Percent of children ages 2-5 years receiving WIC services with the body mass index (BMI) at or above 85th percentile. *Annual Performance Objective for 2011 = 80%*.

The Annual Performance Indicator for FSM for 2009 is 3.3%. This is much lower than

the Annual Performance Objective for the year. The first part of the Performance Measure (WIC Services) is not applicable to FSM, therefore FSM, at the beginning, never collect and report data for this performance measure. During the 2007 MCH Grant Review, the Federal staff of the MCHB recommended that FSM should ignore the part relating to WIC and collect to report data on BMI of children 2-5 years old. In 2009, Chuuk reported (3%) 22 out of 800 children are at or above the 85th percentile, Kosrae reported (2.5%) 21 out of 812, Pohnpei reported (1.5%) 9 out of 580, and Yap reported (14%) 28 out of 205 were at or above the 85th percentile.

National Core Performance Measure #2 - The degree to which the State assures family participation in program and policy activities in the state CSHCN Program. *Annual Performance Objective for 2011= 95%*

The Annual Performance Indicator for FSM for 2009 is 48.3%. This is about half, less than the performance objective for the year.

In the absence of a CSHN Survey, the MCH staff used IFSP and IEP to collect information from parents with children having special health care needs. Families were asked if they are participating in decision-making and being satisfied with services they received. Out of the total 448 CSN families surveyed 100% responded “Yes”. FSM MCH and CSN program will continue effort to meet the target objective by collaboration and partnership with other related agencies and sectors. The specific developments had been done and will continue to be included: (1) Family members continue to participate on advisory committees (2), financial support for parent activities (3), family members are involved in in-service training, and (4), family members of diverse cultures are involved.

Traditionally, families in the FSM have received health care services, but have not participated in the planning of the service system or in developing the policies of the program. The CSHN Coordinators are continuing to work on involving families by including the parent groups in the interagency agreements, and to include parents in the meetings of the CSHN Interagency Council. The parents in all of the four states have organized and have started parent networks, organization and support groups which have become active in advocating for services for the families and children with special needs.

National Core Performance Measure #15 - Percent of women who smoke in the last three months of pregnancy. *Annual Performance Objective for 2011= 1.5%*

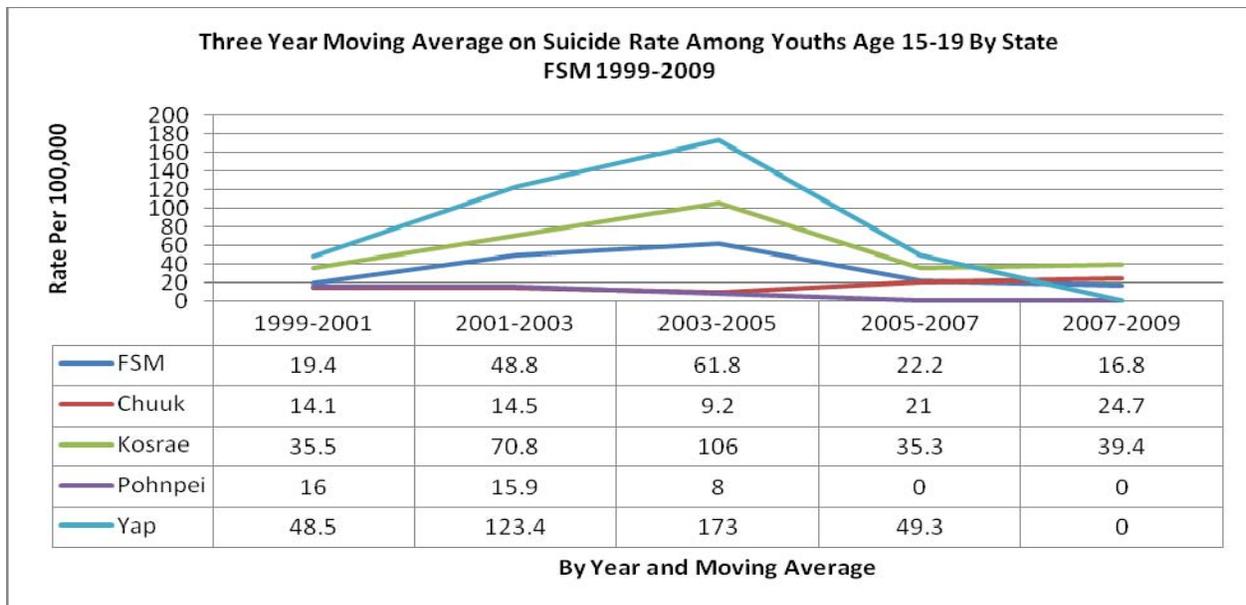
The Annual Performance Indicator for FSM for 2009 is 2%, which is slightly above the targeted objective for the year. During 2009, of the 2157 pregnant women who delivered a live baby, there were 17 live born infants with very low birth weight of less than 1500 grams. Although the VLBW indicator for the FSM has been met (0.8%) based on the Healthy People 2010 Objective of 0.9%, FSM should continue its efforts and pay more attention to the

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nutritional aspects, especially at prenatal period. This number is still represents a high in the number of infant with very low birth weight and in light of the fact that overall 34.7% of the pregnant women in the FSM in 2009 initiated care in the first trimester and approximately 40% of women received less than the 80% of the required prenatal case based on the Kutelchuk Index of Adequacy of Prenatal. Based on this data, the MCH Programs in the four states are planning activities to bring women in earlier for prenatal care and to assure that continuous prenatal care is provided.

National Core Performance Measure #16 - The rate (per 100,000) of suicide deaths among youths 15-19. *Annual Performance Objective for 2011= 2/100,000*

The Annual Performance Indicator for FSM for 2009 is 21.4/100,000. This is higher than the target objective for the year. This rate is based on officially reported deaths in the four FSM states among the projected estimate of 13,970 youths in the age group for the Year 2009. Chuuk reported 2 teen suicide deaths and Kosrae reported 1 teen suicide death. Both Yap and Pohnpei States reported “0” or no teen suicide deaths.



Source: FSM DHSA, MCH Program

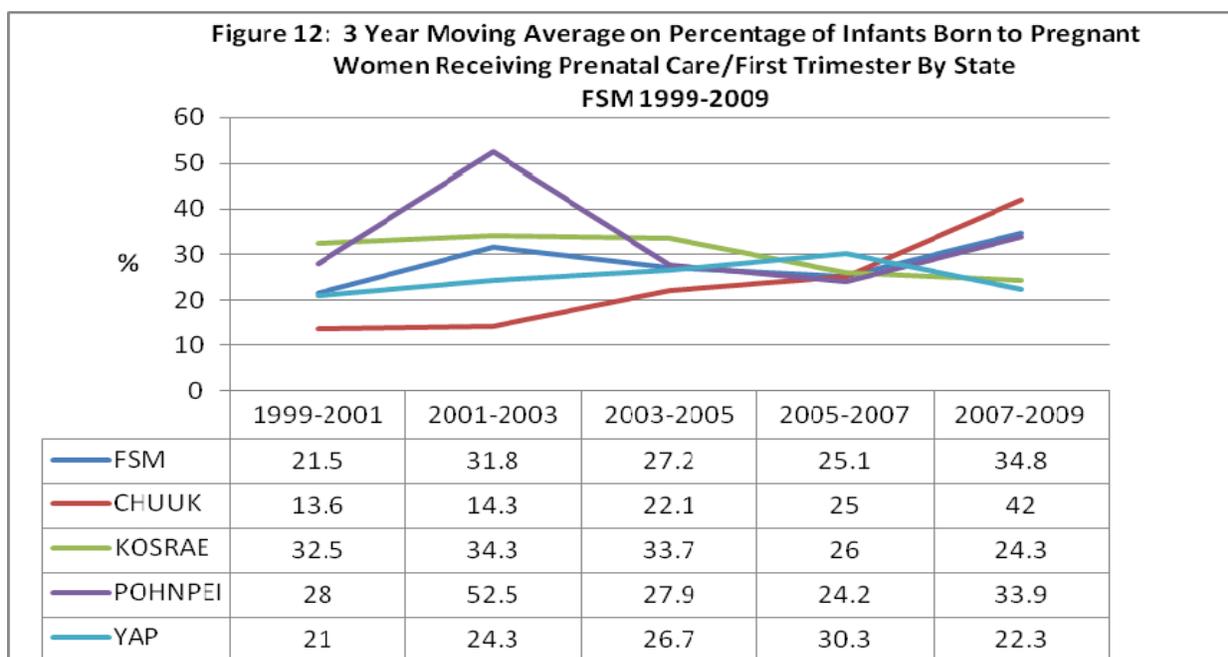
In examining the data for 2005 to 2009, the FSM average indicates slight increase. The individual states indicate high in the smaller states (Kosrae and Yap) and low in the bigger states (Chuuk and Pohnpei). This may not be true because Chuuk has the more problems in general suicide. Many suicide cases oftentimes are classified as accident, especially those that happened at home with handguns and shotguns. The doctor who estimated the causes of deaths either classified under, “Unknown” or followed the report from the family members, because it is shameful and embarrassing on the part of the family or clan. Many of these suicide deaths that

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occur in the outer islands and in the remote villages are not reported. Again, death due to suicide is not culturally acceptable so that many of these deaths are either not reported or the death is attributed to other causes. In running the 3 years average, it is increasing and with the fact of under reporting, it is significant. MCH will continue working with the Women and Youth officers at both the national and state levels and various local, state and national leaderships to deal with this issue.

National Core Performance Measure #17 - Not applicable for FSM

National Core Performance Measure #18 - Percent of infants born to pregnant women receiving prenatal care in the first trimester. *Annual Performance Objective for 2011= 90%*



Source: FSM DHSA, MCH Program

The Annual Performance Indicator for FSM for 2009 34.7%, which is much lower than the targeted objective for the year. In 2009, FSM reported 34.7% of women came in early for prenatal care, a decrease from 40.4% in 2008. The three-year running averages for the period from 2005 to 2009 shows that more women are coming in early for prenatal care. In assessing the percentage of early prenatal care rates in the four states in 2009, Chuuk State recorded the highest percentage with 48% (410/858) of the women receiving early prenatal care; Pohnpei State reported 27% (241/891), Yap reported 24% (57/233) and Kosrae reported 22.8% (40/175) pregnant women getting early prenatal care. Women receiving late prenatal care have been a major problem for many years in the FSM and the increasing trend in the proportion of women receiving early prenatal care is encouraging.

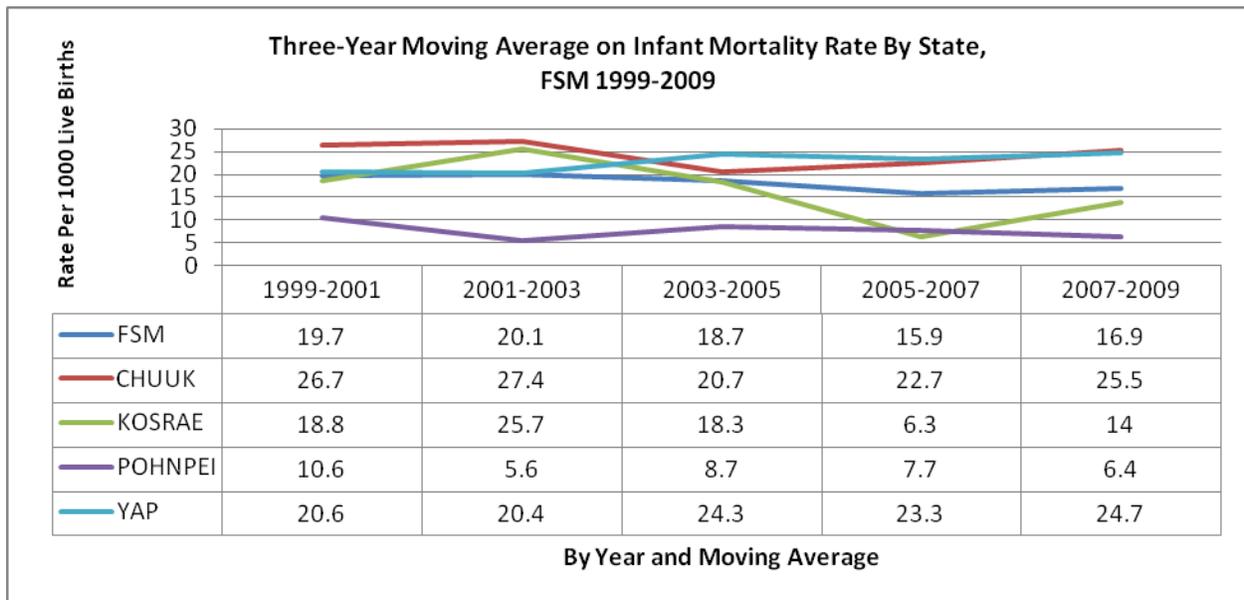
11. Seek Resources

The FSM MCH Program will continue to collaborate with the other public health programs (i.e., Immunization Program, Comprehensive Cancer Control Program, HIV and AIDS Program, Diabetes Control Program, Family Planning Program, and TB and STD Program, Mental Health and Substance Abuse Program, and the Tobacco Control Program) to utilize their expertise and services that affected the MCH Population.

The FSM MCH Program will also continue to work with donor partners in seeking specialized health care services that are needed by the MCH Program population but cannot be provided in the country.

12. Progress on Outcome Measures.

National Outcome Measure #1 - The infant mortality rate per 1,000 live births. *Annual Outcome Objective for 2011= 8/1000 live births.*



Source: FSM DHSA, MCH Program

The Annual Outcome Indicator for the FSM for 2009 is 13/1000 live births, which is higher than the targeted objective for the year. In examining the three year running averages for infant mortality rates between 2005 and 2009, it shows that the rate for infant mortality in the FSM is on an increasing trend. In assessing infant mortality rate in the four states in 2009, Chuuk reported the highest rate at 43/1000, followed by Kosrae at 28.2/1000, Pohnpei at 24.1/1000 and Yap with the lowest at 21/1000. All of the States reported decreases in 2009 except for Pohnpei, which reported an increase. This could be that the reporting is improving. However, a major concern for Pohnpei MCH program is the high teen pregnancy rate. Interpretation must also

considered other factors such as: (1) the confidence level of the validity of the data being reported by the state vital statistics office for both live births and infant deaths is not high; and (2) the statistical anomaly of the small number problem where one event either way can change the rate dramatically. The calculating of the three year running averages does tend to even out the fluctuations in the data. Because of the small numbers of live births and the small numbers of infant deaths, it is difficult to show any relationship between the accomplishments achieved with the performance measures and the decrease in the infant mortality rates. It is anticipated that with the addition of the MCH Data Clerks (through the SSDI Project to improve the state data capacity) to assist in the completion of the birth certificates and the infant death certificates that the validity and accuracy of the number of infant deaths will increase.

In 2009, the IMR varied widely among the four states with Chuuk state having the highest rate for the past five years with the average of 23.3/1000 Live births. Yap reported 22.2/1000 live births lead over Chuuk at 20.1/1000, followed by Kosrae at 12.1/1000 live births and Pohnpei with 6.2/1000 Live birth. The primary causes of death included: prematurity, infections (gastroenteritis, respiratory infection), and meconium aspiration. In Chuuk state there were 16 infant deaths recorded in 2009 of which 10 were in the neonatal period and 6 in the postneonatal period. The primary causes of death included: infection (gastroenteritis, respiratory infection), prematurity, meconium aspiration, injury, malnutrition, and asphyxia. For Pohnpei state there were a total of 4 infant deaths during 2009 of which 3 were in the neonatal period and 1 in the postneonatal period. The primary causes of death include: prematurity, congenital anomalies (2 heart disease (VSD) and anencephaly), and respiratory infection.

National Outcome Measure #2 - The ratio of the black infant mortality rate to the white infant mortality rate (Not Applicable to FSM). *Annual Outcome Objective = NA*

National Outcome Measure #3 - The neonatal mortality rate per 1,000 live births. *Annual Outcome Objective for 2011=6/1000 live births.*

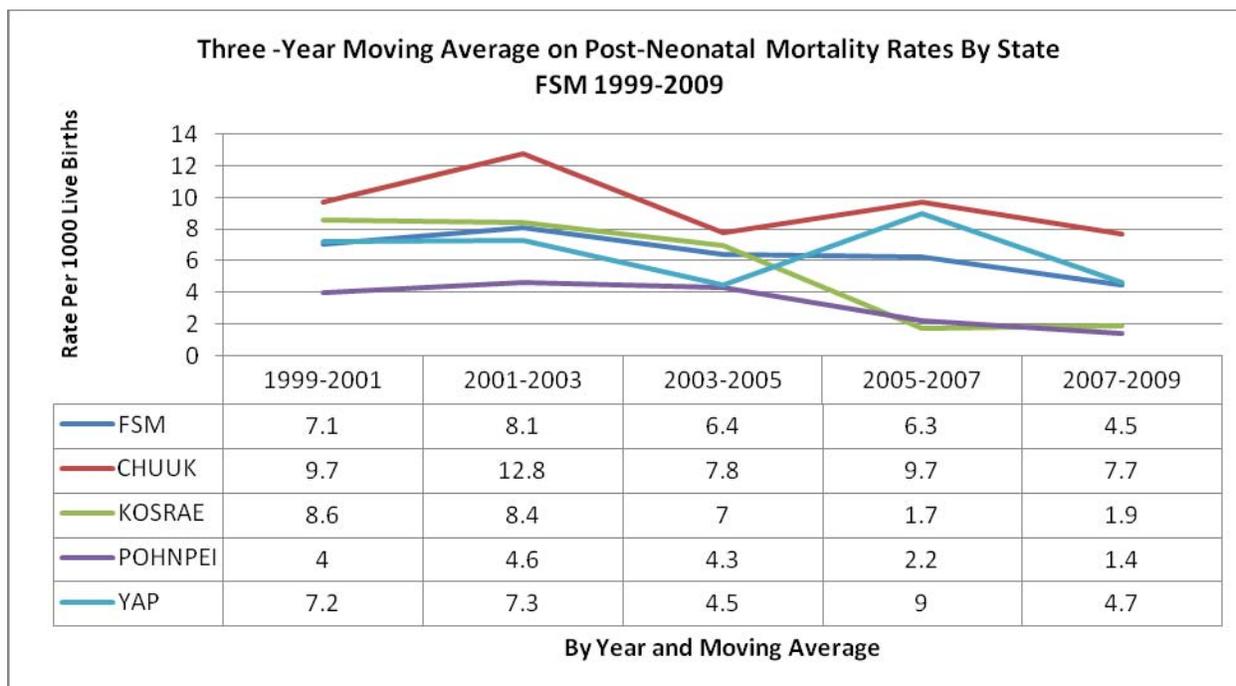
The Annual Outcome Indicator for the FSM for 2009 is 9.3/1000 live births. This is slightly above the targeted objective for the year. However, care must be taken in interpreting the data because of the problems of calculations with the small number of neonatal deaths. During 2009, there were a total of 20 neonatal deaths that were reported from the four states with Chuuk state reporting 10, Yap reported 4 and Kosrae and Pohnpei reported 3 each. See discussion for National Outcome Measure #1 for detail on causes of death.

National Outcome Measure #4 - The post neonatal mortality rate per 1,000 live births. *Annual Outcome Objective for 2011= 2 live births.*

The Annual Outcome Indicator for the FSM for 2009 is 3.7/1000 live births, which is slightly lower than the targeted objective for the year. However, care must be taken in interpreting the data because of the problems of calculations with the small number of neonatal

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death. During 2009, there were a total of 8 post neonatal deaths that were reported from the four states with Chuuk state reporting 6 of the deaths, account for about 75% of all FSM. In examining the data for 2005-2009, there was a decreasing trend from 2007 with 6.3/1000 and with 4.5/1000 live births in 2009. In examining with the 3 Year average, there is a slight decreasing trends but not significant. See discussion for National Outcome Measure #1.



Source: FSM DHSA, MCH Program

National Outcome Measure #5 - The perinatal mortality rate per 1,000 live births + fetal deaths. *Annual Outcome Objective for 2011= 15/1000 live births + fetal deaths*

The Annual Outcome Indicator for the FSM for 200 is 31.5/1000 live births + fetal deaths which is over the targeted objective for the year. In assessing the data for the four states, Chuuk had the highest rate with 37 perinatal deaths (42.7/1000 live birth); followed by Pohnpei with 22 perinatal deaths (24.1/1000 live birth + fetal deaths), Kosrae with 5 (28.2/1000 live births + fetal deaths) and Yap State with also 5 perinatal deaths (21/1000 live births + fetal deaths). The data for state's perinatal mortality rates with the percent of women who received early prenatal care and the percent of women whose observed to expected prenatal visit ratio is greater than 80% was compared to see if there were any association between these factors. There does not appear to be a relationship between perinatal mortality and early prenatal care in that Chuuk state with the highest perinatal mortality rate also had the highest percent of women receiving early prenatal care and Pohnpei has the second highest perinatal mortality rate also has the second highest percent of women receiving early prenatal care. There may be a relationship between perinatal mortality and the number of prenatal care visits in that Kosrae state with the second

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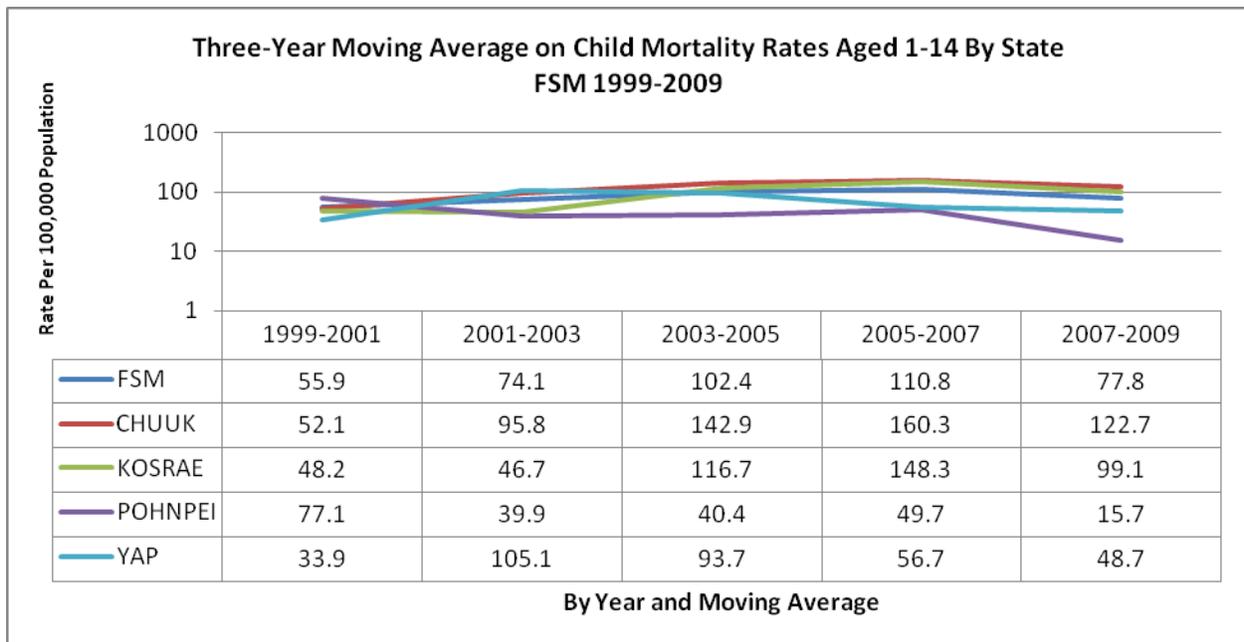
lowest perinatal mortality had the highest proportion of women who received more than 80% of the observed to expected prenatal visits. Further epidemiological analysis of the data will need to be performed to determine the significance of the rates.

National Outcome Measure #6 - The child death rate per 100,000 children aged 1-14.
Annual Outcome Objective for 2011=20/100,000.

The Annual Outcome Indicator for the FSM for 2009 is 35.9/100000 children aged 1-14, which is below the targeted objective for the year. During 2009, the four states reported a total of 14 childhood mortalities between the ages of 1-14 out of a projected population of 39,013 based on the FSM 2000 Census. In examining the 2009 data by states, Kosrae State reported the highest rate with 74.3/100000 (2 out of 2690 children 1-14 years of age), followed by Chuuk with 65/100000 (12 out of 18,502 children 1-14 years of age).

Both Pohnpei and Yap States reported “0” or no deaths of 1-14 years of age.

Because of the small base population, it is difficult to determine whether the data of child deaths reflects a significant increase in the number and rate of deaths or if this is due to a situation of data reporting. Because of the wide variations from year to year, three year running averages for 2005-2009 were calculated and reveals that the mortality rate for children age 1 through 14 in the FSM seemed to have started to decline since 2007 from 110.8/100,000 to 77.8/100,000 in 2009.



Source: FSM DHSA, MCH Program

There appears to be a declining trend; however, it is too early to determine whether trends

have been established and data will need to be collected for a few more years.

13. Develop An Action Plan

The Annual Plan for FY 2011 for the Federated States of Micronesia is based on selected performance and outcome measures at both the national and at the state levels for each of the level of service. The population groups will describe the activities for each of the levels of the services.

DIRECT HEALTH CARE SERVICES. The activities will focus on the state negotiated performance measure that include: (1) Infants who are exclusively breastfed at six months of age, (2) Pregnant women receiving nutrition education and counseling during their pregnancy, (3) Caretakers of infants who receive education and counseling related to feeding and nutrition of infants.

For pregnant women and mothers, the Title V programs in all the four FSM states will continue to provide direct health care to all pregnant women who initiate prenatal care at each State Public Health, regardless of the trimester they enter to the system. These direct health care services include the basic and routine prenatal care for first visits and revisits and high-risk prenatal care. Other direct health care includes weight and blood pressure monitoring, all laboratory services, such as urinalysis, complete blood counts at no cost to the women. After the delivery, 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. Staff whose salaries are borne by the MCH Title V Program or the Family Planning Title X Program provides the cost of contraceptives and family planning services. Contraceptives are provided by Title X and the United Nations Population Fund (UNFPA), which complements all US Title X programs throughout the Federated States of Micronesia. Other direct care services include the provision of education to the mothers on the importance of exclusive breast-feeding (this is done by MCH staff and other public health nurses during prenatal care services and post-partum visits). The MCH program will continue to provide all these services at the Public Health clinics. Yap and Pohnpei States have begun extending follow up prenatal services to the outlying dispensaries. High-risk women are encouraged to return to Public Health clinic at the central health center due to lack of laboratory capability and other specialized services available in the out-lying dispensaries.

For infants and children, the promotion of exclusive breast-feeding is an FSM –wide initiative, which requires all newborns to be put to breast shortly after birth, right in the delivery room. The FSM MCH Program has joint international efforts to promote exclusive breastfeeding for newborns and infant up to six months of age. Some of the international activities include submitting and passing legislation on the International Marketing of Breast Milk Substitutes. By joining efforts with UNICEF and WHO, the MCH Title V Program supports the Baby Friendly Hospital Initiative. All State Hospitals currently have existing policies encouraging exclusive breastfeeding for six month and prohibiting baby bottles and teats from being brought to the hospitals. This policy will continue to be enforced to maintain the high level of mother discharged from the hospitals that are breastfeeding their infants. The FSM SSDI Project is in the process of developing an expanded well baby clinic visit. Mothers with infants under six months

of age will be encouraged to continue to exclusively breastfeed. Also part of the system will include the development of a Well Baby Clinic Form that will collect the appropriate data and the development of a computerized well baby care database.

Another major activity of the SSDI Project will address the problem providing the caretakers of infants with anticipatory guidance and education by developing a system of the expanded well should be expected for children who may have handicapping conditions and who may be eligible to receive individualized services appropriate to their health or medical problems. With the development of the expanded well baby/well child clinic, two components of the services will assist in the early identification of children with suspected handicapping conditions. One of the components will be the developmental screening of all infants up to 18 months of age to screen for developmental delay; and the other component is the performance of physical examinations by the nurses. These activities will assist in the earlier identification of children who are suspected of having handicapping condition.

ENABLING SERVICES. The activities will focus on national and state performance measures: (1) Children in the CSHN Program who have a “medical/health home”. (2) Children with Special Needs who have a completed reevaluation by the CSHCN Team.

For pregnant women and mothers, the MCH Program will increase their efforts to provide outreach services to remote areas to assure the initiation of early and continuous prenatal care. With continuing low rates of women receiving early and adequate prenatal care coupled with the high rates of infant mortality and fetal mortality, the promotion of early and continuous prenatal care is important in improving the health outcomes of infants and children. Yap state will plan to provide training for women from the outer islands and the remote villages on Yap Proper. The training will include the basics of prenatal care, screening, nutrition education, and breastfeeding.

For infants and children, the MCH Program will maintain their efforts to provide outreach services to remote villages and outer islands to assure that children are provided with health screening services and immunization services.

For children with special needs, the four FSM states will continue to assure that every child in the CSHN Program has a “medical/health home”. Because of the unique situation in FSM, all medical and health care services are provided by each State Hospital and the Public Health Division. When a child is referred and accepted in the CSHN Program, the CSHN Physician becomes the primary physician. In addition, because of the close working relationship between the CSHN Program and the MCH Program, all preventive health care services provided to well babies and children are provided to all children with special needs. The CSHN Program will continue to provide home visits and outreach services for children with special needs who have difficulty accessing the CSHN Clinic for assessment and follow up due to transportation problems. For example in Chuuk state, some of these families live on the lagoon islands and it may be necessary to take a one-hour boat ride to the island.

During 2009, the CSHN data show that the CSHN Program is not receiving the number of referrals as expected for children who are suspected of having a handicapping condition and who may be eligible to receive individualized services appropriate to their health or medical

problems. With the development of the expanded well baby/well child clinic, two components of the services will assist in the early identification of children with suspected handicapping conditions. One of the components will be the developmental screening of all infants up to 18 months of age to screen for developmental delay; and the other component is the performance of physical examinations by the nurses. These activities will continue to be reinforced and encouraged to assist in the earlier identification of children who are suspected of having a handicapping condition.

The CSHN data also show that children are being referred to the program, receive an initial evaluation and are provided the initial services and children are receiving follow-up for individual medical problems; however, a comprehensive annual re-evaluation is not being conducted. In order to better document the progress and improvements that a child has made as well as to identify any new special needs that may have developed, a comprehensive re-evaluation for children in the CSHN Program should be conducted on an annual basis. The plans for this year will be to continue to schedule appointments for children who have not received a re-evaluation within 12 months of the original evaluation. The policies, the procedures, the format, and the forms for conducting comprehensive evaluations have already been developed and are in place.

POPULATION BASED SERVICES. The activities will focus on the following national and state performance measures: (1) Women receiving services in the MCH Program who receive a Pap smear screening. (2) Pregnant women screened for Hepatitis B surface antigen, (3) Immunization rates of 2 years old children, (4) Teen-age birth rates, (5) Protective sealants in third grade children, and (6) Mortality rates of children 1-14 due to motor vehicle injuries.

For pregnant women and mothers, the MCH Program will continue to offer Pap smear screening services to women who received services in one of the MCH Program including family planning services, first prenatal care visits, post-partum clinics. The MCH Coordinator and Family Planning Coordinator will also monitor the results of the Pap smear and will assure the appropriate and timely referral of women with positive Pap smears and to assure appropriate and timely treatment for those who have a confirmed diagnosis.

Between 25% to 50% of children infected before 5 years of age become carriers, whereas only 8% - 10% of acutely infected adults become carriers. Therefore, prevention strategies for populations in which HBV infection is endemic are directed at vaccinating infants with Hepatitis B vaccine, usually within 24 hours after birth, to prevent both prenatal and childhood transmission of infection. Because the prevalence of hepatitis B infection is high among the population in the FSM, the MCH Program will continue to assure that all pregnant women are screened for Hepatitis B surface antigen and the infant of any women with a positive screen shall receive HB Immune Globulin followed by the immunizing infants with the Hepatitis B vaccine.

In an effort to curtail the rising birth rate to teen age women, the MCH Program will collaborate with the Family Planning Program and conduct at least one youth seminar on family planning awareness, and to continue to refer teenagers to the Family Planning Program for counseling and education. The MCH Program will provide pamphlets on family planning methods to the teenagers who are encountered at any of the MCH clinics and will provide family

life education at the schools, and will continue to include family planning services as part of the MCH program when going out to the field when providing other services.

For **infants and children**, the MCH Coordinator will continue to work in collaboration with the Division of dental Services to apply sealants on at least one permanent molar tooth for the third graders. The MCH Program will provide the portable equipment, dental units, and the sealants and the Dental Division staff will provide the professional services to go into the schools and provide protective sealants on molars of third grade children.

In 2009 there were no deaths reported of 1-14 year old children due to motor vehicle injuries; however, in 2005 a rate of 23.1/100,000 was reported. These vehicle crashes involve mostly adults who were driving while under the influence of alcohol. In FY 2011, the MCH staff will continue working closely with the Mental Health Program in each of the four states to educate the public on the dangers involved in drinking alcohol and driving. In addition, the MCH program will continue to collaborate and support the department of public safety to continue with its education and public awareness programs and to continue to enforce traffic laws, with strict handling of those driving under the influence of alcohol.

Preventing vaccine preventable illness and death in children through an active and comprehensive immunization program is one of the major efforts of the MCH Program. The staff of the MCH Program will focus on increasing the number of outreach services to provide immunizations to the outer islands, lagoon islands, and remote villages.

There are no population-based services planned for the children with special needs population.

INFRASTRUCTURE BUILDING SERVICES. The activities will focus on the following national and state performance measures: (1) Children in the Head start Program who have been screened for diseased, missing, and filled teeth, and (2) Development of a preventive dental health program in MCH, (3) Suicide deaths among youths, and (4) Infants born to mothers receiving early prenatal care.

For **pregnant women and mothers**, one of the major problems is the fact in 2004, only 14.7% of the mothers who delivered an infant initiated care in the first trimester. In order to increase the percentage of pregnant women receiving early prenatal care, the MCH Program is planning to provide prenatal care services in the communities. Currently, the majority of the prenatal services are provided at the Public Health Clinic at the central hospital facility only and women from the rural areas have difficulty with transportation and childcare. Services will include (1) counseling pregnant women who come in late to come in early during their next pregnancy; (2) the use of ultrasound to confirm the pregnancy and to confirm the gestational age; (3) constant and frequent public announcements on the importance of early prenatal care.

For **infants and children**, the MCH Program will work in collaboration with the Early Childhood Education Program (formerly Head start Program) and the Division of Dental Health to survey the status of dental disease among children attending the Early Childhood Education Program. The purpose of this survey is to determine the magnitude and the severity of the dental

problems in Early Childhood Education (ECE) children that will assist in the development of a preventive dental health education program.

Another major activity of the MCH Program will be the further development of the expanded well baby care system of services. During 1999, the Well Baby Care Policy and Procedure Manual were developed with clinical forms and data collecting forms. A Newborn Registry database was developed as a central registry for scheduling and monitoring appointments. For FY 2006, some of the main activities will be the introduction of growth monitoring with plotting of measurements on the growth curve, routine developmental screening, and the development of parent education modules.

For **children with special needs**, the staff of the CSN Programs will continue to evaluate and improve the system of care for children with special needs. Some of the activities that are planned for FY 2006 are the evaluation of the procedures of the interdisciplinary team conducting service plans, the re-negotiation of the interagency agreement and the creation of a national interagency committee.

14. Allocate Resources and Monitor Progress

The findings from the CSN survey conducted four years ago and the FSM MCH Program needs assessment conducted this year lead to some important deficiencies, within the health care system, and to some specific health issues that the MCH Program focused its resources and activities as its priorities. The issues that were noted in the needs assessment were also augmented by recommendation from other experts to the FSM government for the need to provide coordinated and persistent array of social, medical and preventive services to improve the health of the women, mothers, infants and children who make up at least 90% of its total population.

Child protection is the buzz word these days. FSM government had acceded to numerous international treaties that protects the health and welfare of the children, including mothers and infants. For example, the Convention on the Rights of the Child, FSM government committed itself to this convention and tasked the FSM Department of HSA, the Title V Agency, as the lead agency. The Framework Control Tobacco Convention (FCTC) – FSM has promised the world to reduce the harmful effect on the people, especially the most vulnerable who are women, infants and children.

In May 2005, the MCH and the Special Education Programs conducted their 3rd annual Joint Workshop in Kosrae State. Representatives from both the National and State MCH and Special Education programs and other collaborating departments and agencies attended this four-days workshop. The underlying goal of the workshop was to find ways where the two programs can collaborate and in partnership improve early intervening services for infants and toddlers and their families. Also, during the workshop, the MCH Program coordinators and staff from each of the FSM States and the National discussed issues such as AMCHP meetings, legislative updates, and writing of work plans. The work plans set out what each of the MCH Program coordinators would do for the priorities already set out. Together, they reviewed the work plans, discuss ways to track progress, and agreed on timeline for reports to be submitted. When the agreement was

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made, the FSM National MCH Program allotted the funds to the respective State MCH Programs to carry out the activities. Unless the FSM Government says otherwise, this system will be followed in allotting funds to the respective State programs. The process in setting work plan will also be followed.

In addition, each year the FSM MCH Program will review its performance as it prepares for each year submission of its annual grant application. This opportunity will also serve as an opportunity to know progress made.

APPENDICES:

Table 1. Chuuk State MCH needs and issues for the Next Cycle.

	Pregnant Women & Mothers	Infants & children (0-14 yrs).	Adolescent (15-19 yrs)	Children incl CSN
Direct Services	comfortable seating in waiting area; Provide water dispenser;	Reduce teen suicide, teen pregnancy; More frequent specialized medical team visits; Pediatric care (cardio, dental)	Intensify effective health education & awareness;	Provide hearing devices to hearing impaired children thru Sped & EDHI
Enabling Services	ANC available in periphery; increase prenatal care and awareness/health education; Folic acid must be available; Need additional competent staff; Expand existing FP/WB services; Breast cancer screening (mammogram machine); Adequate space delivery/labor room; Increase # of outreach visit; Re-establish partnership w/	Extend well-baby clinic in periphery; Ensure availability of Vitamin A & de-worming; Ensure availability of ferrous with minerals (0-1yrs);(1-5yrs); Decrease malnutrition & diarrhea, skin disease, respiratory infection, injury–counsel on prevention of illness; Increase oral	HPV vaccines; Increase health education and awareness in community on abstinence, drug abuse, nutrition family planning, health status; Determine if student is able to do P.E.; Physical exam before school year starts for students; Establish partnership with Public Safety and Health Services to decrease juvenile	Identify lab that can receive specimens for genetic and environmental screening; Increase outreach activity to outer regions; Strengthening partnership with SpEd on education and health (3-21 yrs); Provide hearing devices to hearing impaired children thru SpEd & EDHI; Ensure that each child has IEP, IFSP for 0-3 yrs;

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	<p>agriculture dept. thru NGO's with seedlings provided for mothers (i.e. gardening, healthy lifestyle); Counseling on unwanted pregnancies and child abandonment; Awareness and education on contraceptives; Identify support group (Breastfeeding support group, CWC) and upgrade knowledge and skills; Adequate space delivery/labor room; Increase # of outreach visit; Appropriate use of limited resources; Appropriate screening of high risk; Provide blood bank; Radio Conference.</p>	<p>hygiene education and awareness ,</p>	<p>arrests(include Pub Safety with training on drug abuse; Increase action/prevention on STI's;</p>	<p>Refer child to "uninsured funds" program with Referral Committee at Chuuk Health Service; Establish priority service for CSN "anytime" in outpatient(i.e. if patient is sick and needs treatment with physician; Have card system for faster service); Fund availability for transportation for CSN to see visiting physicians.</p>
<p>Population based</p>	<p>Pap smears screening at selected dispensaries (need supplies, lights, exam table, test kits, skilled; Breast cancer screening (mammogram machine), Start providing inferno injection or IV to anemic mothers; Adequate space</p>	<p>Extend well-baby clinic in periphery; Ensure availability of ferrous with minerals (0-1yrs);(1-5yrs) decrease malnutrition & diarrhea; Oral hygiene to be part of well-baby clinic.</p>	<p>HPV vaccines; Increase health education and awareness in community on abstinence; Physical exam before school year starts for students; Determine if student is able to do P.E.; Establish partnership with</p>	<p>Strengthening partnership with SpEd on education and health (3-21 yrs); Provide hearing devices to hearing impaired children thru SpEd & EDHI; Ensure that each child has IEP, IFSP for 0-3 yrs; Refer child to</p>

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	<p>delivery/labor room; Counseling on unwanted pregnancies and child abandonment; Awareness and education on contraceptives; Identify support group (Breastfeeding support group, CWC) and upgrade knowledge and skills; Appropriate use of limited resources.</p>		<p>Public Safety and Health Services to decrease juvenile arrests(include Pub Safety with training on drug abuse.</p>	<p>“uninsured funds” program with Referral Committee at Chuuk Health Service; Establish priority service for CSN “anytime” in outpatient(i.e. if patient is sick and needs treatment with physician.</p>
<p>Infrastructure building</p>	<p>personnel/training, ensure availability of supplemental vitamin, iron, ferrous; Risk assessment; Updating ANC protocols and providing availability; Retraining of staff; Involve mothers in care of children (i.e. moms weighing babies).</p>	<p>Funding support for development and printing of materials for protocol.</p>	<p>Re-activate interagency to address adolescent problems; Funding support for development and printing of materials for protocol.</p>	<p>Funding support for development and printing of materials for protocol.</p>

Table 2. Kosrae State MCH Program needs and issues for the Next Cycle.

	<p>Pregnant Women & Mothers</p>	<p>Infants & children (0-14 yrs).</p>	<p>Adolescent (15-19 yrs)</p>	<p>Children incl CSN</p>
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Direct Services	ANC; Screening pap smears; LAMSE training; Medications.	Reduce teen suicide, teen pregnancy; More frequent specialized medical team visits; Pediatric care (cardio, dental).	Physical exam	Medications must be available at all times.
Enabling Services	Improve STI screening, assessment, counseling; Improve health education, campaign, awareness; Provide comprehensive risk assessment for all NCDs; Provide LAMASE training by trained personnel; Provide dental check/screening; Provide ultrasound machines, fetal monitor, Doppler; Provide mobile clinic; Provide and strengthen the Td and IN1 vaccines; Change clinic hours to evening hours; Need to have one vehicle.	Vaccination; Tools and equipment to conduct annual physical exam; Provide deworming meds, nut supplements; Provide health maintenance; Provide newborn hearing screening.	Increase vaccination rates for HPV, H1N1; Increase rates of dental exam, physical exam; Improve nutrition status; Decrease VitA deficiency; Decrease suicide rate; Increase and improve sexual abuse prevention and education; Decrease attempted rape rate; Increase counseling; Provide after school education program; Institute health education at the high schools and COM.; Provide workshops /activities to increase awareness on life skills; Provide education and awareness on TB,HIV, substance abuse and decrease rates.	Assistive devices; Maintain good interagency collaboration/services for CSHCN; Improve access to basic health care; Hire CSHCN staff/nurse; Explore special ed and MCH /other program or scheme funds to offset insurance and medical cost; Physiotherapy training for staff or caretakers; Specialized training (speech, audio, physio, activities to increase parental involvement in care of children.
Population	Family planning,	Vaccination; Vitamins	HPV vaccination; H1N1;	Maintain good interagency

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based		supplements; Newborn hearing screening.	Family planning; Substance use; STI; Rape; Health education at the high schools and COM; NCDs; HIV; Substance abuse; STIs.	collaboration/services for CSHCN; Specialized training (speech, audio, physio, activities to increase parental involvement in care of children.
Infrastructure building	LAMASE training;	Funding support for development and printing of materials for protocol.	Establish protocol for SCAN workshops/activities to increase awareness on life-skills.	Physio therapy training for staff or caretakers; Specialized training (speech, audio, physio, activities to increase parental involvement in care of children.

Table 3. Pohnpei State MCH Program needs and issues for the Next Cycle.

	Pregnant Women & Mothers	Infants & children (0-14 yrs).	Adolescent (15-19 yrs)	Children incl CSN
Direct Services	Transportation provided by government; Medical supplies; Equipments; Hired OBGYN; Additional examining room; Use of calendar to track menstrual cycle.	Up to date immunization (0-5 yrs.) free medical charge; Maternity leave; Car seats for infants; Enforcement of traffic law relating to driving while holding kids; Babies leaning out of car windows; Low and very low birth weight relate to pregnant women; Infant mortality;	Reduce teen pregnancy; Increase peer counseling; Strengthening Law Enforcement for sexual abuse; Child support; Continue education and screening for STI; Suicide...is it a problem? <ul style="list-style-type: none"> ▪ Family breakdown in extended family system; ▪ Discipline; High school dropouts; Scheduling SAHM counseling for children	Child support; Updated IEP on every child; Strengthen and expand IAC; Social security and Medical insurance Benefits; Specialized services and referrals; Custom made vehicle for transportation for the safety of children; Equipment (assistive devices) for CSHCN; Card system for CSHCN Priority

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		Continue promote breast feeding; Space for breastfeeding in working area.	and parents at AHD Clinics;	Service; IEP start up before entering ECE; Strengthen Multi Disciplinary IEP Team; Vision and Hearing Specialist.
Enabling Services	Transportation provided by government; Medical supplies; Equipments; Hired OBGYN; Additional examining room; Use of calendar to track menstrual cycle.	Free medical charge; Maternity leave; Car seats for infants; Enforcement of traffic law relating to driving while holding kids; Low and very low birth weight relate to pregnant women; Continue promote breast feeding; Space for breastfeeding in working area; Family breakdown in extended family system; Discipline.	Increase peer counseling; Strengthening Law Enforcement for sexual abuse; Child support; Continue education and screening for STI; Scheduling SAHM counseling for children and parents at AHD Clinics.	Child support; Updated IEP on every child; Strengthen and expand IAC; Social security and Medical insurance Benefits; Specialized services and referrals Custom made vehicle for transportation for the safety of children; Equipment (assistive devices) for CSHCN; Card system for CSHCN Priority Service; IEP start up before entering ECE; Strengthen Multi Disciplinary IEP Team; Vision and Hearing Specialist.
Population based	STI, adequacy of first trimester visit, ensure availability of pregnancy test kits, conduct regular pregnancy risk factors	Maternity leave; Car seats for infants; Enforcement of traffic law relating to driving while holding kids; Babies leaning out	Reduce teen pregnancy; Suicide...is it a problem? High school dropouts.	Specialized services and referrals; Equipment (assistive devices) for CSHCN; Card system for CSHCN Priority Service;

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	survey, dental screening and care, de-worming.	of car windows; Low and very low birth weight relate to pregnant women; Infant mortality; Continue promote breast feeding.		Strengthen Multi Disciplinary IEP Team.
Infrastructure building	Prenatal care treatment protocol; Adoption of WHO model; Maternity/paternity leave.	Neonatal intensive care unit, Breastfeeding policy, Baby friendly hospital, protocol for newborn hearing screening; Babies leaning out of car windows.	Interagency agreement; Expansion of Adolescent Health and Development Project at private school.	Updated IEP on every child; IEP start up before entering ECE.

Table 4. Yap State MCH Program needs and issues for the Next Cycle.

	Pregnant Women & Mothers	Infants & children (0-14 yrs).	Adolescent (15-19 yrs)	Children incl CSN
Direct Services	Pregnant women and mothers; Prenatal care, FP, STI screening, nutri counseling, risk assessment, pap smears, dental.	Hearing screening, immunization, growth monitoring, well-baby, breast feeding, counseling, spacing counseling, physical exam.	VitA, school health screening, FP, STI screening, NCD risk factors (BMI, level of physical activity, nutritional practices, substance abuse, counseling.	Additional assistant (staff), assistance with Shriner's , medical care off-island, phenobarb, dilantin, Ritalin, visits by physical therapist, psychiatrist, neurologists.
Enabling Services	Counseling, training and retraining health assistant and birth attendant, community assessment by community	Interagency coordination with CHC, Special Education, availability of refrigerators to keep vaccine in	Child find, homebound visit by CHC, Special Education and MCH, positive reinforcement of life learning skills.	Insurance, ongoing services by Special Ed and Medical staff, training for parents or care takers on parenting skills, smoking and chewing betel nut and tobacco

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	members, second hand smoking.	the outer islands, secondhand smoking.		cessation, second hand smoking, priority status given to children with special needs.
Population based	STI, adequacy of first trimester visit, ensure availability of pregnancy test kits, conduct regular pregnancy risk factors survey, dental screening and care, de-worming.	Education for care takers, day care facility adequate prenatal care, nutritional and vitamins, dental services.	Parenting skills training, instilling sense of personal and citizenship responsibility, self esteem, spiritual and mental wellbeing, family planning, youth friendly facility, peer education center, de-worming.	Dental services, sealant, de-worming.
Infrastructure building	Prenatal care treatment protocol by Mitch Besser, WHO model, maternity/paternity leave.	Neonatal intensive care unit, Breastfeeding policy, Baby friendly hospital, protocol for newborn hearing screening.	Interagency agreement and forming health clubs at school.	Policy for priority status, more education to parents to utilize special program services (Sped/MCH).

List of Participants by State

**Chuuk State Needs Assessment Workshop
List of Participants**

Day 1.

	First Name	Last Name	Position/Title
1.	Silla	Angesom	Med. Record Specialist
2.	Cherlyn	Asito	MCH Data Clerk
3.	Kathy	Mori	CSHCN Coordinator
4.	Sablon	Remit	Physician
5.	Enrida	Pillias	Family Planning Coordinator
6.	Siana	Shapucy	OBGYN/CSH Physician
7.	Robert	Umwech	Health Special Education
8.	Siana	Heldart	Pediatric Ward Nurse
9.	Dita	Weito	OB Nurse
10.	Markita	Buliche	OB Ward Nurse
11.	Anamaria	Yomai	CSHCN Physician
12.	Petewon	Betroell	Peer Educator, Youth Center
13.	Lineina	Graham	CWC Board Member
14.	Jeycina	Robert	Parents Representative
15.	Ume	Fritz	Federal Grants Coordinator
16.	Ansina	Kony	Special Education Coordinator
17.	Keth	Serious	Public Safety
18.	Danty	Disa	Mens clinic/Youth Center
19.	Karsom	Enet	Executive Director
20.	Alex	Narruhn	Health Educator, Env. Health
21.	Andita	Meysline	MCH Coordinator
22.	Beatrice	Hashigndri	MiCare Health Insurance, Chuuk
23.	Susan	Danis	CWC Member

Day 2.

	First Name	Last Name	Position/Title
1.	Chineina	Graham	CWC Member
2.	Keth	Serious	Public Safety
3.	Siana	Shapucy	CSH Physican
4.	Alex	Narruhn	Env. Health
5.	Petewon	Betwell	Youth Friendly Center (HIV)
6.	Sablon	Remit	Physician
7.	Kachie	Sana	POSCA/Consumer
8.	Jeycina	Robert	Parent Rep.
9.	Siena	Heldart	
10.	Anamaria	Yomai	CSHCN Physician

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11.	Ume	Fritz	Federal Grants Coordinator
12.	Dita	Weito	CSH
13.	Rita	Mori	Physician
14.	Markita	Buliche	CSH
15.	Silla	Angesom	Statistic Spec.
16.	Cherlyn	Asito	MCH Data Clerk
17.	Kathy	Mori	CSHCN Coordinator
18.	Susan	Danis	CWC Member
19.	Batsipa	Sarafin	CWC Member
20.	Andita	Meysine	MCH Coordinator
21.	Enrida	Pillias	Family Planning Coordinator
22.	Sipa		CWC Member

Kosrae Needs Assessment Workshop

Participants List

Day 1.

	First Name	Last Name	Title/Position	Contact
1.	Cecilia	Sigrah	MCH Nutritionist	CSigrah@fsmhealth.fm
2.	Tame	Sigrah	OB Nurse	TSSigrah@fsmhealth.fm
3.	Kenye	Mongkeya	Midwife Nurse	Finfiki104@yahoo.com
4.	Tholman	Alik	Physician	tholalik@yahoo.com
5.	Elterina	Shrew	Supervisor (Midwife)	elshrew@hotmail.com
6.	Patricia	Melander	MCH Coordinator	pmelander@fsmhealth.fm
7.	Paul	Aaron	Physician	Pabsa03@yahoo.com
8.	Roslyn	Reynold	Chief, Public Health	rosreynold@yahoo.com
9.	William	Palik	Parents Rep.	
10.	Foster	Waguk	TB Coordinator	yelum@hotmail.com
11.	Annie	Siba	MCH Nurse	asiba@fsmhealth.fm
12.	Rose	Joe	MCH Data Clerk	

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Day 2.

	First Name	Last Name	Title/Position	Contact
1.	Cecilia	Sigrah	MCH Nutritionist	CSigrah@fsmhealth.fm
2.	Tame	Sigrah	OB Nurse	TSSigrah@fsmhealth.fm
3.	Kenye	Mongkeya	Midwife Nurse	Finfikil04@yahoo.com
4.	Tholman	Alik	Physician	tholalik@yahoo.com
5.	Elterina	Shrew	Supervisor (Midwife)	elshrew@hotmail.com
6.	Patricia	Melander	MCH Coordinator	pmelander@fsmhealth.fm
7.	Paul	Aaron	Physician	Pabsa03@yahoo.com
8.	Roslyn	Reynold	Chief, Public Health	rosreynold@yahoo.com
9.	William	Palik	Parents Rep.	
10.	Foster	Waguk	TB Coordinator	yelum@hotmail.com
11.	Annie	Siba	MCH Nurse	asiba@fsmhealth.fm
12.	Rose	Joe	MCH Data Clerk	
13.	Rissey	Waguk	CNM	Rpwaguk@fsmhealth.fm
14.	Maria	Zyaila	OBGYN	M2zzol@yahoo.com
15.	Lorinda	Mongkeya	OR Nurse	
16.	Lilly	Jonas	Physician	
17.	Marylinda	Timothy	Immunization Coordinator	
18.	Salome	Martin	Family Planning Coordinator	

**2010 MCH Needs Assessment – Pohnpei State
List of Participants**

Day 1- May 13, 2010

Name	Office	Position/Title	Contact #
1. Cindy M. Hambrosio	Health Services	MCH Data Technician	320-2214
2. Carmen Jim	Public Health	CSHCN Coordinator	320-2217
3. Adelihner Ioanis	ECE/DOE	Health Specialist	320-2705
4. Rihna Jimmy	PDOE/Div. C&I	Education Spec. (Health)	320-2105
5. Jutina A. Olter	Special Ed/CHC	Advisory Council/Board of directors	320-6298
6. Hermis Edmond	Public Safety	Police Captain	320-3592
7. Aileen Mauricio	Public Health	SAMH A. Coordinator	320-6138
8. Florentina Martin	Parents	Parents	320-2214
9. Tony Martin	HPO	Field Research	320-2652
10. Yumiko Paul	PHC	MCH Coordinator	320-6613

Day 2- May 14, 2010

Names	Office	Position	Contact #
1. Florentina Martin	Parent	Parent	320-2214
2. Justina Olter		Sped-A/C	320-6298
3. Margaret P. Oliver	Sped	Physical Therapist	320-6529
4. Carmen Jim	PH	CSHCN Coordinator	320-6613/2217
5. Hermis Edmond	Public Safety	Police Captain	320-3592
6. Rihna Jimmy	DOE	Ed. Spec. (health)	320-2105/2106
7. Yumiko Paul	MCH/PHC	MCH Coordinator	320-6613
8. Cindy Hambrosio	Health Services	MCH Data Technician	320-2214/2215
9. Tony Martin	HPO	Fields Researcher	320-2652
10. Albertina Lemuel	PSH	Pediatrician	320-2215
11. Aileen Mauricio	SAMH	SAMH Coordinator	320-6138
12. Kipier Lippwe	FSM Health	NCD Program Manager	320-2619

**Yap Needs Assessment Workshop
List of Participants**

Day 1.

First Name	Last Name	Position/Title
1. Ms. Denitha	Palemar	MCH Coordinator
2. Ms. Janet	Fichiwemang	CSHCN Coordinator
3. Ms. Naty	Malgarsoh	Family Planning Coordinator
4. Ms. Julie	Yoruw	Chief, Public Health
5. Ms. Cindy	You	MCH Data Clerk
6. Ms. Leona	Tamag	Yap Womens Association
7. Mr. Peter	Hasugulmal	Physician
8. Mr. Callistus	Saplaelug	Health Assistant
9. Ms. Esther	Letalimepiy	Health Assistant
10. Ms. Angelica	Agapito	OBGYN
11. Ms. Gemvieve	Marpa	Parents
12. Ms. Agatha	Legasiuggiy	Midwife
13. Ms. Johanna	Malimai	Parents Representative
14. Mr. John	Malimai	Community Representative
15. Ms. Joan	Rutuu	Special Education, Admin. Officer

Day 2.

First Name	Last Name	Position/Title
1. Mr. Callistus	Sapluelug	Health Assistant

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2. Ms. Johanna	Malimai	NIWA Representative
3. Mr. John	Malimai	Father/Pastor
4. Dr. Peter	Hasugulmal	Physician
5. Mr. Peterson	Suwei	Nurse
6. Mr. Frank	Lifang	NCD Coordinator
7. Ms. Esther	Letalimepiy	Health Assistant
8. Ms. Julie	Yoruw	Chief, Public Health
9. Ms. Naty	Malgarsoh	Family Planning Coordinator
10. Ms. Geinivieve	Marpa	Mother, NIWA Representative
11. Ms. Lucy	Bigelow	Quality Assurance Coordinator
12. Ms. Denitha	Palemar	MCH Coordinator
13. Ms. Janet	Fichiwemang	CSHCN Coordinator
14. Ms. Joan	Rutuu	Special Education, Admin. Officer
15. Ms. Cindy	You	MCH Data Clerk

References

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² US Department of Health and Human Services, 2005. *HRSA MCH Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report, Fifth Edition*, Rockville, MD. (OMB No. 0915-0172). Maternal and Child Health Bureau, HRSA.