



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



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1.4 Overview of the State

The Federated States of Micronesia (FSM) is an island nation consisting of approximately 607 islands in the Western Pacific Ocean. The Nation of the FSM lies between one degree south and fourteen degrees north latitude, and between 135 and 166 degrees east longitude. Although the total area encompassing the FSM, including its Economic Exclusive Zone (EEZ), is very expansive, the total land area is only 271 square miles with an additional 2,776 square miles of lagoon area. The 607 islands vary from large, high mountainous islands of volcanic origin to small flat uninhabited atolls. The FSM consists of four geographically and politically separate states: Chuuk, Kosrae, Pohnpei, and Yap.

Based on the 1999 estimated projections of the 1994 Census, the total population of the FSM stands at 113,032 residents. The distribution of the population among the four states shows that the state with the smallest population is the State of Kosrae with 7,691 residents (6.8% of FSM total); the next largest population is in the State of Yap with 11,856 persons (10.5% of FSM total); Pohnpei state has a total population of 36,146 (32% of FSM total); and the largest population is in the State of Chuuk with 57,339 residents (50.7% of FSM total). Of this total population of 113,032, there are 25,320 women of child-bearing years of 15-44, which is 22% of the total population. Of this total population of child-bearing age women, there are 4,030 women between the ages of 15-17 years. The population structure continues to show that 59,560 (53%) of the residents - more than half of the population are under the age of 20 and the children from birth through five-year old number 15,643 and comprise 13.8% of the population.

The **State of Chuuk** consists of 15 high volcanic islands in the Chuuk Lagoon and a series of 14 outlying atolls and low islands. There are three geographic aspects to Chuuk, the administrative center of the state on the island of Weno (formerly Moen), the islands of the Chuuk Lagoon, and the islands of the outlying atolls - a total of approximately 290 islands in all. The 15 islands of the Chuuk Lagoon have a total land area of 39 square miles; and the lagoon itself has a total surface area of 822 square miles and is surrounded by 140 miles of coral reef. The islands of the Chuuk Lagoon include:

Northern Namoneas -17,093 Weno (Moen) Fono	Southern Nemoneas -11,898 Tonoas Totiw Fefan Tsis Parem Uman	Faichuk -12,671 Tol (Tol, Polle, Patta) Eot Romanum Fanapanges Udot
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There are three groups of outer islands: The Mortlocks, The Hall Islands and the Western Islands.

The Mortlocks (Nomoi) Islands - 6,471 population Upper Mortlocks - Nama and Losap Islands Mid-Mortlocks - Namoluk, Etal, Satowan atoll Lower Mortlocks - Lukunor, Southeast Satawan	
The Hall (Pafeng) Islands and Western Islands (Oksoritod) - 5,186 population Houk Murillo Onouo Fananu Polowat Onoun Unanu Ruo Pollap Makur Piherarh East Fayu Island (uninhabited) Tamatom Nomwin	

The total population of the State of Chuuk based on the 1994 Census was 53,319 residents and of this total,

41,662 (78% of total state including Weno) live on the islands in the Chuuk Lagoon. The administrative center, Weno Island claims 16, 121 residents (30% of total state), followed by Tol (4,816), Fefan (4,042), Tonoas (3,949), Uman (3,056), Patta (1,825), Udot (1,598), Wonei (1434), and Polle (1,320). The remaining islands have less than 750 residents each. In assessing the age distribution of the population in Chuuk, of the 53,319 total residents 57% (30,314 persons) of the population are under 20 years of age. Of this group, 8,440 are children under 5 years of age. The median age in Chuuk is 17.0 years which makes this the youngest population in the FSM. There are 11,005 (42% of the female population) women of child-bearing ages between 15-44 that live in the state.

Because of the vast expanse of water between islands, travel within the State of Chuuk is difficult. Within the lagoon, travel by boat from Weno to any of the other islands will take from 1.5 hours to 2 hours. Access to the outer islands is even more difficult with travel times on a cargo ship taking from four hours up to two days. The provision of health care to the population of Chuuk is made difficult because of the wide distribution of small clusters of the population among the the islands coupled with the fact that there is no transportation system that allows access to these islands.

The **State of Kosrae** is the only single-island state in the FSM and the furthest southeastern point of the four FSM states. The Island of Kosrae is the second largest inhabited island in the FSM (Pohnpei being the largest) with a land area of approximately 42.3 square miles. Because of the steep rugged mountain peaks, all of the local villages and communities are coastal communities that fringe the island and are connected by paved roads. Travel around Kosrae island is not difficult and it is possible to drive from one end of the island to the other end in approximately two hours of easy driving. The inner part of the island is characterized by high steep rugged mountain peaks, with Mount Finkol being the highest point of Kosrae at 2,064 feet above sea level. The island is surrounded by low-lying reefs and mangrove swamps. The state is divided into the four municipalities of: Lelu, Malem, Utwe, Tafunsak. The community of Wailung (approximate population of 200) is part of Tafunsak municipality, is isolated and only accessible by a ½hour boat ride at high tide. The capitol of Kosrae is Tofol where the majority of the government buildings and offices, the single high school, and the Kosrae Stae Hospital are located. Also part of Tofol are the offices of private businesses including the Continental Micronesia office, the Bank of Hawaii, Bank of FSM, FSM Development Bank, two restaurants and one hotel.

The total population of Kosrae, based on the 1994 Census data, is 7,317 residents. Of this total population, 2,427 people reside in Tafunsak, 2,404 persons in Lelu, 1,430 in Malem, and 1,056 residents on Utwe. In assessing the age distribution of the population, 53% (3846 persons) of the population is less than 20 years of age and of that group 922 (13%) are less than 5 years of age. The population of women 15-44 years number 1,512 and comprise 43% of the total female population.

The **State of Pohnpei** consists of the main island of Pohnpei and eight smaller outer islands. The island of Pohnpei is rectangular in shape, is approximately 13 miles long and has a land mass of 129 square miles, and is the largest island in the FSM. The island itself is a high volcanic island with a central rain forest and a mountainous interior. The elevated interior has eleven peaks of over 2,000 feet with the highest peak, Nahnalaud at 2,595 feet above sea level. Pohnpei proper is encircled by a series of inner-fringing reefs, deep lagoon waters and an outer

barrier reef with a number of islets found immediately off shore. The island of Pohnpei is subdivided into five municipalities and the central government town- the municipalities of Madolenihmw, U, Nett, Sokehs, Kitti, and the town of Kolonia where the majority of the government buildings and offices, and the Pohnpei State Hospital are located. Of the outer islands of Pohnpei, to the south lies Kapingamarangi (410 miles from Pohnpei proper), Nukuor (308 miles), Sapwuahfik (100 miles), Oroluk (190 miles), Pakin (28 miles), and Ant (21 miles). To the east lies the islands of Mwoakilloa (95 miles) and Pingelap (155 miles). These outer islands together comprise a land mass of approximately 133 square miles and 331 square miles of lagoons.

The population of Pohnpei, based on the 1994 Census data, numbered 33,692 residents and is projected to reach 37,800 by the year 2000 and 48,700 by the year 2014. More than half (55%) of the population (18,348 persons) of Pohnpei are less than 20 years of age with the median age of 18.2 years. There are 7,407 women of child-bearing age between 15-44 years and they comprise 45% of the female population.

Travel on the island of Pohnpei proper is increasingly easier with the increased development and improvement of paved roads to outlying communities. However, because of scattered housing along secondary unpaved dirt roads, there are still many residents who have a difficult time in accessing health care. The outer islands are the most difficult to reach because of the infrequent and undependable cargo ships. The regular field trip on the ship takes place once a month to each of the outer islands bringing supplies and health personnel to deliver goods and services.

The **State of Yap** lies in the western most part of the Federated States of Micronesia. Yap proper is the primary area in Yap State and is a cluster of four islands (Yap, Gagil-Tomil, Maap, Rumung) connected by roads, waterways, and channels. Most of the coastal areas are mangrove with occasional coral beaches. The town of Colonia on Yap proper is the capital of Yap. The State of Yap has a total of 78 outer islands stretching nearly 600 miles east of Yap Proper Island of which 22 islands are inhabited. Although these islands encompass approximately 500,000 square miles of area in the Western Caroline Island chain, Yap State consists of only 45.8 square miles of land area. Most of the outer islands are coral atolls and are sparsely populated. The population distribution among these island based on the 1994 Census data are: *Yap Proper* with 65% (6,919 persons) of the population; *Ulithi Lagoon* has four inhabited islands (Asor, Falealop, Fatharai, Mogmog) with a population of 1,016 residents (9.1%); *Wolaei* is comprised of two lagoons (the West Lagoon and the East Lagoon) with five of the 22 islands inhabited with a population of 844 persons (7.6%); *Fais*, population 301; *Eauripik*, population 118; *Satawal*, population 560; *Faraulep*, population 223; *Ifalik*, population 653; *Elato*, population 121; *Ngulu*, population 38; and *Lamotrek*, population 385.

The total population of Yap state, based on the 1994 Census data, stands at 11,170 which is a 9.8% increase over the 1989 data. The Yap population comprises 10.6% of the total population of the Federated States of Micronesia. The median age for Yap is 19.7 years and is the highest median age among the four states and comparatively higher than the median age of the FSM which is 18.1 years. The age distribution of the population in Yap shows that 50.5% are under 20 years of age (3,354 persons); there are 2661 women between 15-44 years of age, the child-bearing years which is 47% of the total female population.

Similar to the Island of Pohnpei, transportation on Yap Proper is becoming easier because of the development and improvement of paved roads; however, there are clusters of villages that are still difficult to access because of unpaved dirt roads. The outer islands are also difficult to reach because of the infrequent cargo ships. The regular field trip on the ship takes place once a month to each of the outer islands bringing supplies and health personnel to deliver goods and services.

Within the FSM, the health care delivery environment differs for each of the four states and depends on the availability of resources, the geography of the state, and the extent to which the health care system has been decentralized - as recommended in the 1995 FSM Economic Summit. The center of each State's health system is the hospital. Each contains an emergency room, outpatient clinics, inpatient wards, surgical suites, dialysis unit, a dental clinic, a pharmacy, laboratory and X-ray services, physical therapy services, and health administration offices which includes an office for data and statistics. In addition to these acute care services, the Public Health clinic services are provided either within the same facility as the hospital or in a separate facility on the grounds of the hospital. These central hospitals are located on the island of Weno in Chuuk State, in the municipality of Lelu in Kosrae State, in Kolonia on the island of Pohnpei, and in Colonia on the island of Yap Proper. These hospitals and its services are directly accessible only to residents of the urban (state) centers. For residents who live on the lagoon islands or the outer islands, access is more difficult because of the lack of public transportation between the islands. In addition to these centralized facilities for both medical care and public health services, each of the four states are in the process of decentralizing the system to be able to provide health care services in outlying and remote areas. The State of Chuuk and the State of Yap both have dispensaries in the outer islands as part of the Primary Health Care Division that are served by health assistants. Only the basic of health care services are available in these sites and consultation with medical personnel at the hospital is necessary for more complicated medical care. The State of Pohnpei and the State of Kosrae are extending services into the communities through the improvement and expansion of community-based dispensaries which are served by medical and health personnel from the public health programs who travel to these out-lying dispensaries either on a daily basis or several times a week to provide services.

Other indicators that have an impact on the health status of the MCH population in the FSM are the level of poverty among the population. In the State of Yap, in the 1994 census, of the 1,925 households, 1,426 reported some cash income with a median household income of approximately \$6,000 and a mean household income of \$8,300. By region, the median household income was \$6,700 in Yap Proper and about \$3,800 in the outer islands. During this reporting year, about 50% of the population aged 15 years and over reported receiving cash income. These 3,401 income recipients represented half of the 6,754 persons in the working age population. The median individual income for Yap was \$3,509 with individual income on Yap Proper higher than income in the outer islands.

1.5 The State Title V Agency

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. This re-organization merged the former Departments of Health, the Department of Education, and the Historic Preservation and Archives Program into a new *Department of Health, Education and Social Affairs (HESA)*.

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, now under the administration of the new Department of Finance and Administration.

1.5.1 State Agency Capacity

No materials included

1.5.1.1 Organizational Structure

There are two levels of government in the FSM, the National Government level and the State Government level. At the National level, the Secretary of the Department of Health, Education and Social Affairs (HESA) manages health affairs for the nation.. The FSM Title V Maternal and Child Health Program, as the designated State Health Agency, is at the National Government level, and is one of the programs under the Secretary, Department of Health, Education and Social Affairs (HESA). The National MCH Coordinator works under the Secretary of HESA as well as in collaboration with other coordinators at the national level, such as the Immunization Coordinator, the Family Planning Coordinator, the HIV/AIDS Coordinator and the Diabetes Control Program Coordinator. Two additional positions funded by the Title V Program at the National Government level include one MCH Administrative Assistant and the Federal Program Coordinator. The day-to-day administration and management of the Title V Program is under the direct control of the National MCH Coordinator, who also works closely with each of the four state MCH Coordinators. At the state levels, the Department of Health Services is headed by the Director of Health who is appointed by the Governor of the State and is responsible for all medical and health services in the state. Organizationally, in Pohnpei State directly under the Director of Health are the Chief of Medical Services who is responsible for hospital based medical services and the Chief of Primary Health Care Services who is responsible for all public health services and functions, and the Chief of Dental Services. In Kosrae State, the three divisions are Division of Administrative Services, Division of Curative Services, and Division of Preventive Health Services. Each state has a central State Hospital with medical, nursing, and support personnel that provide all of the acute inpatient and outpatient medical services for the residents of the state. The Maternal and Child Health Program and the Children with Special Health Care Needs Program are both organizationally under the Chief of Primary Health Care Services. For the planning, implementation and provision of direct services to the maternal, infant, child, and adolescent populations, each state has an MCH Coordinator and a Children with Special Health Needs (CSHN) Coordinator.

1.5.1.2 Program Capacity

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 1999, there were 36 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. 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 work closely with the staff from other programs to provide the full array of services. Some of the other programs that collaborate with the MCH Program include the family planning program, the immunization program, the school health program, the prenatal care program, and the STD program.

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 CSN Clinic by the CSN physician who provides the medical and health care to the children with disabilities. The program staff also provide services to the children and families in the home when warranted. The CSN Program has been developed as an interagency effort among the MCH Program, the Chuuk State Hospital, the Special Education Program, and the Headstart Program.

Because of the wide distribution of the population among the Lagoon Islands and the outer islands, the MCH Program has started an outreach program to serve women and children who live in remote locations. Teams of physicians and nurses travel to these remote islands to provide prenatal services, immunization services, screening services, and dental services.

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 urinalysis. The women are also screened for Hepatitis B, STD's, and cervical cancer with a Pap smear. The tetanus booster is updated and they are 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 attend 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 followup services for infants and children who are referred with handicapping conditions. For children who are homebound, the CSN team will make home visits to provide medical and educational services. The CSN Program is an interagency effort among the MCH Program, the Special Education Program, the Headstart 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 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 an 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 operates under the supervision of the Chief of Primary Health Services. The 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, urinalysis, 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 women 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 followup with the physician through the CSN Program Coordinator. The Pohnpei CSN Program is an interagency effort among the MCH Program, the Special Education Program, the Headstart Program, and the physician and physical therapist from the hospital. The MCH staff 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 takes 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 Children with Special Needs program provides clinical assessment for children suspected of having a handicapping condition. Medical followup is provided by the Public Health physician and the CSN Coordinator, who is a Public Health Nurse. The Yap CSN Program is an interagency effort among the MCH Program, the Special Education Program, the Headstart Program, and the physician and physical therapist from the hospital.

1.5.1.3 Other Capacity

Within each of the four states, under the direction of the State Director of Health, the Division of Public Health 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. There were 36 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. 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 work closely with the staff from other programs to provide the full array of services. Some of the other programs that collaborate with the MCH Program include the family planning program, the immunization program, the school health program, the prenatal care program, and the STD program.

The planning, evaluation, and data analysis are provided by the MCH Coordinators in each of the four states with the support from the Coordinators of other programs such as the Immunization Program and the Family Planning Program as well as from the staff of the National MCH Program. Technical assistance through consultation visits twice a year is provided by the SSDI consultant from the University of Hawaii, School of Public Health. Of the four MCH Coordinators, three are Registered Nurses and one is a Medical Officer and all are also responsible for assuring that clinical services are provided to pregnant women, infants, children, and children with special needs.

1.5.2 State Agency Coordination

The MCH Title V Program staff at the state level work closely with the Special Education Programs of the Department of Education, Headstart Program, the Dental Health Divisions of each state health services; Family Food Production and Nutrition (FFPN) Program (a UNICEF-supported program located at each State Department of Agriculture), parents support groups, church leaders, women's groups, community and traditional leaders.

In the four states, an interagency agreement for the Children with Special Needs Program has been developed that involves the Children with Special Needs Program, MCH Program, the State Hospital, the Department of Education, Special Education Program, the Headstart Program, and the Parent Network. This

interagency agreement has been established to assure that children are screened for disabilities, and those who are suspected of having a disability are referred to the Children with Special Needs Program for an assessment. The agreement also assures that an interdisciplinary team of members from each of the agencies is available to conduct an assessment, develop the individualized plan, and provide or coordinate the services.

In 1999, the Governor of Chuuk State established a new task force - The Chuuk State Children Task Force - and appointed members from the community to serve and includes the MCH Coordinator. The Children with Special Needs Coordinator and the UNICEF Nutrition Advisor were appointed as Co-Chairpersons for this task force. The task force is charged to assess the issues related to the Children's Rights Convention as ratified by the FSM National Government. One of the first tasks of this group is to identify and examine existing laws and regulations that protect the rights of children. Also in Chuuk, there is the Chuuk State Inter-Agency Nutrition Committee, which is designed to promote any nutrition activities for Chuuk State. This Committee has assisted MCH Program to do more breast-feeding education by training women's groups in the communities on the importance of exclusive breast-feeding and the impact on the health of infants and children.

The MCH Program is organizationally part of the Primary Health Care Services Division (public health services) which also includes the Family Planning Program, the prenatal care program, the Immunization Program, the HIV/AIDS Prevention Program, mental health services which includes the alcohol and substance abuse programs, School Health Program, the NCD (non-communicable diseases - hypertension, diabetes) Program, and the Tuberculosis and Leprosy Program. Because all of these programs and services are under the supervision of the Chief of Primary Health Care Services Division, coordination of services among these programs is possible.

The FSM does not have the following programs or services: Title XIX - Medicaid, Title XXI - Child Health Insurance Program, social services, child welfare programs, Social Security Administration, WIC Program, or rehabilitation services.

2.1 Annual Expenditures

See Form 3 - State MCH Funding Profile; Form 4 - Budget Details by Types of Individuals Served; and Form 5 - State Title V Programs Budget and Expenditures by Types of Services.

2.2 Annual Number of Individuals Served

See Form 6 - Number and Percentage of Newborn and Others Screened, Confirmed and Treated; Form 7 - Number of Individuals Served (Unduplicated) Under Title V; Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX; and Form 9 - MCH Toll-free Telephone Line Reporting Form.

2.3 State Summary Profile

See Form 10 - Title V Maternal and Child Health Block Grant Services Profile.

2.4 Progress on Annual Performance Measures

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 mother, and well baby care services for infants. 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 anemia, STD, Hepatitis B, and diabetes. At each clinic visit, weight and blood pressure monitoring is provided. During 1999, in Chuuk, there were 1,215 women who were provided with prenatal care services of which only 69 who initiated care during the first trimester. In Kosrae, a total of 216 women were provided with prenatal care services during the year of which 52 women received care starting in the first trimester. In Pohnpei State during 1999 a total of 800 women were provided services in the prenatal clinics; of these women 57 initiated early prenatal care. In Yap, the Public Health Program provided prenatal services for 245 women of whom only 52 initiated care in the first trimester.

Infants and children: The MCH Program in all four states provides newborn and well baby care services, immunization services, school health services, some preventive dental services. Newborn services are provided between two week and one month of age and is the initial visit for the infant. During 1999, the Well Baby Clinic services was re-designed to include an emphasis on anticipatory guidance and preventive education. The components of the clinic includes: (1) Parent interview - Well Baby Clinic services should start with a parent

interview and focus on asking the appropriate "trigger questions" that may elicit indicators of problems or issues that will need to be addressed with education and counseling. These questions should be developmentally appropriate and may be related to breastfeeding, concerns related to feeding issues, sleeping patterns, acute illness, and concerns related to mother's health, or other concerns in the family. A nutritional assessment should be conducted to determine the nutritional intake of the infant or child. (2) Growth measurements - Measurements should be taken at each Well Baby Clinic and Well Child Clinic visit and should include weight and height/length, as well as head circumference measurements (for first year of life). The measurements should be plotted on the appropriate growth curve to determine the percentile of growth in each of the parameters. The health care provider should also interpret the measurements and growth patterns of the infant or child to the parent. If the child is growing well, the parent should be commended and encouraged to continue (3) Immunizations - Immunizations are a primary service provided at Well Baby Clinics. Education and counseling should be provided to the caregivers about the importance of periodic visits to assure that the immunization series is completed at the appropriate ages. (4) Developmental screening - Developmental screening, along with screening for appropriate growth, is one of the most important indicators that can indicate whether an infant is doing well. Developmental screening must be age appropriate and should be conducted at each Well Baby Clinic visit. Infants and children who are suspected of having delays in their development should be referred to the Children with Special Needs Program for a comprehensive assessment. (5) Hematocrit screening - Because the infant is at the highest risk of developing iron deficiency anemia between 9-12 months of age, screening of the blood for hemoglobin/hematocrit should be conducted at this age. If the hemoglobin or hematocrit is low, then a full dietary history should be obtained to determine the level of iron intake. If the dietary history indicates low iron intake, then nutritional counseling and iron therapy should be instituted with appropriate follow-up. (6) Education and counseling - Because of the emphasis on prevention and anticipatory guidance in well baby care, developmentally appropriate education and counseling services are critical for caregivers. Some of the topics that should be covered include: the importance of continuous well baby care, normal developmental progression of infants and children, nutrition and feeding, supplemental vitamins and fluoride, brushing teeth, immunization, recognizing early signs of illness (fever, failure to eat, vomiting, diarrhea, dehydration, skin problems), handling common illness, discipline, safety and injury, and appropriate parent-child interactions. (7) Physical examination - A physical examination should be performed by the MCH Public Health Nurse as a method of screening for physical or medical problems. A physician should be available for referral and consultation for any questionable findings. The physical examination, though thought to be the most important activity is only a small portion of the Well Baby Clinic visit.

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 Headstart Program, the state hospital, and community nutrition programs. The professional staff that are included as part of the interagency team include the CSN 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 Headstart Program. Children who are suspected of having a handicapping condition are referred to the CSN Assessment Clinic where a comprehensive assessment is provided, intervention services are recommended and followup services are provided by the CSN Coordinator or the RSA. Referrals for specialty clinics and specialty services are made through the CSN clinic. As of 1999, there are a total of 562 children registered in the four state CSN Programs.

The following National Core Performance Measures (#1 - #2) and State Negotiated Performance Measures (SP#3 - SP#5) 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 1999 = 4.*

The Annual Performance Indicator for FSM for 1999 is 5. 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.

State Negotiated Performance Measure SP#3 - Percent of infants who are exclusively breastfed at 6 months of age. *Annual Performance Objective for 1999 = 35%*

The Annual Performance Indicator for FSM for 1999 is 35.6%. For the four states, a total of 582 infants out of 1637 infants in the well baby clinic were reported to be exclusively breastfeeding at six months of age. This represents a decline from the 1998 figure when 48.1% of the infants were exclusively breastfeeding. In assessing the data for the individual states, Chuuk state had the highest percentage at 64.5%, followed by Kosrae with 55%, Pohnpei at 13.3% and Yap State with 9.8%. One of the major reasons that Chuuk and Kosrae have a significantly higher rate is because of the fact that these two states have implemented a community-based program where older women are trained to provide the education and support to the younger mothers who are discharged home from the hospital. The importance of assuring breastfeeding is because the causes of infant mortality and morbidity in the FSM are largely due to diarrheal diseases and may be attributed to bottle feeding and early weaning and introduction of other foods besides breast milk. In order to reduce infant mortality in the FSM, the promotion of exclusive breastfeeding has become a nation-wide initiative as a joint collaborative effort between the Federated States of Micronesia and UNICEF and WHO in the "Baby Friendly Hospital Initiative" (BFHI) project.

State Negotiated Performance Measure SP#4 - Percent of pregnant women who receive at least one nutrition education and counseling session (defined as covering the following topics: diet recall, importance of three meals, balanced diets, exercise) as early as possible during their pregnancy. *Annual Performance Objective for 1999 = 95%*

The Annual Performance Indicator for FSM for 1998 is 100%. During 1999, the four states reported that of the 2,260 women who received prenatal care during the year all of them received nutrition education and counseling services. These services are usually provided during the first visit at the clinic no matter what month of pregnancy the women receives care. However, in assessing the nutrition education, there is no consistency among

the four states as to the content of the education.

State Negotiated Performance Measure SP#5 - Percent of caretakers of infants who receive education and counseling related to feeding and nutrition of infants. *Annual Performance Objective for 1999 = 95%*

The Annual Performance Indicator for FSM for 1999 is 100%. During 1999 of the 2839 caretakers who attended well baby clinics all of them are reported to have received education and counseling related to feeding and nutrition of infants. Nutrition problems are still prevalent among many infants and children in the Federated States of Micronesia. Children continue to be admitted to the hospital with dehydration and malnutrition; children continue to be identified with the complications of Vitamin A deficiency; and children continue to fail to thrive. In order to make an impact on these preventable nutritional problems, nutrition education will be a major component of the well baby care services. Nutrition education has been designated as an important component of the well baby care services in the MCH Program for the FSM and therefore all of the nurses and staff in the MCH Program provide this service.

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 each of the four states, the MCH Program provides outreach services in remote rural villages to provide immunization 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 CSN Assessment clinics were provided by the Special Education program. For those children who lived in the rural areas and did not have transportation, home visits by the SSDI Consultant, the interagency team of CSN 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 CSN program.

The following National Core Performance Measure (#3) and State Negotiated Performance Measure (SP#7) 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 1999= 100%.*

The Annual Performance Indicator for FSM for 1999 is 100%. 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 Public Health Division. When a child is referred and accepted in the CSN Program, the CSN Physician becomes the primary physician. In addition, because of the close working relationship between the CSN 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. Therefore, every child in the CSN Program has a medical/health home.

State Negotiated Performance Measure SP#7 - Percent of children with identified developmental problems who are referred to the CSHCN Program. *Annual Performance Objective for 1999 = 100%*

The Annual Performance Indicator for FSM for 1999 is 13.7%. This data reflects the three states of Chuuk, Yap, and Pohnpei only. No data was submitted by Kosrae State. Of the 511 children registered in the CSN data base for the three states, 70 (13.7%) were identified as having a developmental problem.

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 1999, in the four states, there were a total of 2,476 women who received these screening and educational services through the prenatal care clinics. Pap smear screening is also provided to women of all ages through the MCH Program and in 1999, a total of 1301 (49.6%) women of all ages in the four states were provided with a Pap smear screen.

Infants and children: The MCH Program in the four states provided services through the well baby care clinics. Population-based services included developmental screening, growth monitoring, and immunization. Caretakers were provided with age and development appropriate nutrition education and counseling 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 CSN 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 - #10) and State Negotiated Performance Measures (SP#1 - SP#2) are related to the Population-Based Services level in the pyramid.

National Core Performance Measure #4 - Not applicable for the FSM.

National Core Performance Measure #5 - 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 1999 = 66%.*

The Annual Performance Indicator for FSM for 1999 is 68.3%. When the data for the four states of FSM are aggregated, the objective for the year is exceeded. Three of the four states were higher than the objective - Kosrae (80%), Chuuk (70%), and Yap (91%) - however, Pohnpei State only immunized 55% of the 2 year old children. Possible reasons for the lower percentage in Pohnpei is because of the effort of the Division of Primary

Health Care Services to decentralize their services where services are being curtailed at the Pohnpei State Hospital and central public health clinics and moving into the community dispensaries. A cursory review of immunization cards of some children have shown that there is a discrepancy between the documentation of immunizations given on the immunization cards and the central immunization data base. This lack of documentation also adds to the problem in Pohnpei. The success of the other states is 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 outer islands and remote rural villages are provided routinely.

National Core Performance Measure #6 - The birth rate (per 1,000) for teenagers aged 15 through 17 years. *Annual Performance Objective for 1999 = 24/1000.*

The Annual Performance Indicator for FSM for 1999 is 24.6/1000 females 15-17 years, while in 1996, the rate was 28.4/1000 and in 1998 the rate was 34.5/1000 females. In assessing the data for the four states, three of the states were relatively similar - Kosrae (6.8/1000), Chuuk (19.9/1000), Yap (28.2/1000) - however, Pohnpei State had a teen birth rate of 52.3/1000. 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 be a focus of the MCH Program.

National Core Performance Measure #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth. *Annual Performance Objective for 1999 = 10%.*

The Annual Performance Indicator for FSM for 1999 is 27.4%. Of the 3,440 third grade children in the reported by the DOE in the FSM, 622 (53%) of the children in Pohnpei State and 320 (18%) of the third grade children in Chuuk were reported to have received a protective sealants. Kosrae and Yap states reported no children receiving sealants. The MCH Programs work in collaboration with the Dental Services Division to achieve this performance measure. Some of the reasons that the children do not receive sealants is due to the lack of supplies and equipment required for the dental staff to go into the schools to provide the services. The MCH Program 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 field to provide these services.

National Core Performance Measure #8 - The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. *Annual Performance Objective for 1999 = 6.5/100,000 children 1-14 years of age.*

The Annual Performance Indicator for FSM for 1999 is 0/100,000 children 1-14 years of age. There were no reported deaths to children between 1-14 years of age because of motor vehicle accidents. There are very few total deaths in all age groups due to motor vehicle accidents primarily because of the fact that speeding cars are rare

because of the condition of many of the roads in the FSM states. Those areas that are paved with heavy traffic patterns are generally not in the villages where most of the population are residing and where the children are playing.

National Core Performance Measure #9 - Percentage of mothers who breastfeed their infants at hospital discharge. *Annual Performance Objective for 1999 = 100%.*

The Annual Performance Indicator for FSM for 1999 is 99.9%. Although the FSM did not meet the objective of 100%, this high percentage of mothers who are discharged from the hospital while breastfeeding is due to the fact that bottle formula are not allowed in the hospital unless ordered by the physician for medical reasons, all mothers are encouraged and supported to breastfeed their infants, and mothers are not discharged from the hospital until the infant is breastfeeding with no difficulties. The objective of 100% is not realistic because in some cases there are medical reasons for not being able to breastfeed while in the hospital.

National Core Performance Measure #10 - Not applicable for FSM

State Negotiated Performance Measure SP#1 - The percent of women receiving services in the MCH Programs who receive a Pap smear, appropriate referrals for treatment when positive, and follow up after referral. *Annual Performance Objective for 1999 = 99%*

The Annual Performance Indicator for FSM for 1999 is 49.6 % which represents a significant increase over 1998 which documented 15.6%.. During 1999, there were a total of 2624 women receiving services in the MCH Program of which 1301 women received a Pap smear. In assessing the data from the four states, the State of Kosrae provided Pap smear screening for 164 of the 202 women receiving services; in Chuuk, only 504 of 1215 women were screened with a Pap smear; in Yap all of the 280 women received a Pap smear; and in Pohnpei at total of 353 of the 927 women receiving services were screened with a Pap smear. The primary reason given for the smaller number of women receiving a Pap smear than anticipated was the lack of consistent availability of Pap smear kits in the states, disruption of services because of the de-centralization of services into the community.

State Negotiated Performance Measure SP#2 - Percent of pregnant women who have been screened for Hepatitis B surface antigen. *Annual Performance Objective for 1998 = 100%*

The Annual Performance Indicator for FSM for 1999 is 58.6% which is a slight increase over 1998 at 52.2%. The percentage of women screened varied among the four states. Yap State had the highest percentage with 100% of the pregnant women who received prenatal care services and were screened for Hepatitis B surface antigen. In Kosrae, 97% (196/202) of the pregnant women were screened, followed by Pohnpei with 86.4% of the women screened and Chuuk State with 22.6% (275/1215) of the women screened. The primary reason for not achieving the objective is because of the limitation of testing supplies and reagents in Chuuk State.

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.

Infants and children: During 1998, in an effort to establish a consistent standard of care for well baby care,

the MCH Programs in the four states continued to develop the comprehensive well baby care program through the efforts of the SSDI Project. The Newborn Registry data base was developed using EPI-INFO and training was provided in capturing newborn data and data entry. The registry is to be used as the primary method of identifying infants who should be coming to the well baby clinic at two week of age and one month of age. 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.

Children with special health care needs: During 1999, the CSN Program continued to develop the CSN Interagency Assessment Clinic through the efforts of the SSDI Project. In 1999, the referral procedures and forms and the policy and procedure manual were reviewed and changes were made when necessary. Training was provided to the CSN Coordinators on 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 1999, in the four states, there were a total of 562 children in the CSN data base who were assessed and identified as having a significant disability.

The following National Core Performance Measures (#11 - #18) and State Negotiated Performance Measure (SP#6) are related to the Infrastructure Building Services level in the pyramid.

National Core Performance Measure #11 - 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 1999 = 0.*

The Annual Performance Indicator for FSM for 1999 is 0. The FSM is unique in that all medical and health care services are provided by the State Government through the State Hospitals and the Public Health Division. All children in the Children with Special Needs Program receives the available health care services provided by the state. Specialty consultants - orthopedics (Shriners Hospital), cardiologist, ophthalmologists - who provide itinerant services in the four states are available to children in the CSN program. 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.

National Core Performance Measure #12 - Percent of children without health insurance. *Annual Performance Objective for 1999 = 100%*

The Annual Performance Indicator for FSM for 1999 is 100%. The FSM is unique in that all medical and health care services are provided by the State Government through the State Hospitals and the Public Health Division. 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.

National Core Performance Measure #13 - Not applicable for FSM

National Core Performance Measure #14 - The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. *Annual Performance Objective for 1999 = 9.*

The Annual Performance Indicator for FSM for 1999 is 7. The specific indicators include: Family members continue to participate on advisory committees (2), financial support for parent activities (1), family members are involved in in-service training (1), family members of diverse cultures are involved (2). The objective was not met

for 1999. Traditionally, people 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 CSN Coordinators are continuing to work on involving families - the first step was to include the Parent Networks in the interagency agreements, other steps that will be focused on are to include parents in the meetings of the Interagency Council and include parents in the planning of the Title V Grant.

National Core Performance Measure #15 - Percent of very low birth weight live births. *Annual Performance Objective for 1999 = 0.*

The Annual Performance Indicator for FSM for 1999 is 0.9%. During 1999, of the 2,162 women who delivered, there were 19 live born infants with very low birth weight. Although the VLBW indicator for the FSM has been met based on the Year 2010 Objective of 0.9%, this still represents an increase in the number of infants born with low birth weights. This fact is a major concern in light of the fact that overall less than 10% of the pregnant women in the FSM in 1999 initiated care in the first trimester and 75% of the women received inadequate prenatal care based on the Kotelchuk Index of Adequacy of Prenatal Care which takes into account the timing of initiation of prenatal care and the ratio of observed to expected prenatal visits. 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 1999 = 30/100,000.*

The Annual Performance Indicator for FSM for 1999 is 0.1/100,000 youths 15-19 years of age. This rate is based on a total of only one officially reported death in the four FSM states among the 1999 projected estimate of 13,632 youths in this age group. Of the four states, only Pohnpei reported the single suicide death. It is believed by the MCH Coordinators that this number is low due to the fact of under-reporting because of several factors. One of the factors may be that many of these suicide deaths in the outer islands and in the remote villages are not reported. Because it is also felt that a death due to suicide is not culturally acceptable that many of these deaths are either not reported or the death is attributed to other causes.

National Core Performance Measure #17 - Not applicable for FSM

National Core Performance Measure #18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. *Annual Performance Objective for 1999 = 26%*

The Annual Performance Indicator for FSM for 1999 is 9.7%. This represents a significant decrease from 1998 when 20.3% of the women received early prenatal care. During 1999 there were a total of 2365 women who received prenatal care and of these women 230 were reported to have received early prenatal care. In assessing the percentage in the four states, Pohnpei State recorded the lowest percentage with 6.1% (57/927) of the women receiving early prenatal care; Chuuk State reported 6.9% (69/1004) pregnant women getting early care; Yap State had 21.2% (52/245) while Kosrae State recorded the highest percentage at 27.5% (52/189) of the women receiving early prenatal care. The fact that a high percentage of women are receiving early prenatal care in Kosrae may be because of the de-centralization of prenatal services into the five community dispensaries.

State Negotiated Performance Measure SP#6 - Percent of children in Headstart Programs surveyed to determine the rate of decayed, missing, and filled teeth. *Annual Performance Objective for 1999 = 100%*

The Annual Performance Indicator for FSM for 1999 is 47.9% which is lower than the 69.8% of the children who were screened in 1998. This 1999 percentage reflects the States of Chuuk, Yap and Pohnpei only. No data was submitted from Kosrae. Of the 1811 children in the Headstart Program, 868 children (47.9%) received a dental screen.

2.5 Progress on Outcome Measures

National Outcome Measure #1 - The infant mortality rate per 1,000 live births. *Annual Outcome Objective for 1999 = 23/1000 live births.*

The Annual Outcome Indicator for the FSM for 1999 is 19.5/1000 live births. There were 46 infant deaths reported during 1999 from the four states with a total number of 2365 live births. The IMR varied widely among the four states with Kosrae having the highest rate at 31.7/1000; followed by Chuuk with 18.9/1000; Pohnpei State with 20.5/1000 and Yap having the lowest at 8.2/1000. In 1995, the infant mortality rate measured 23/1,000 (62 infant deaths), increased to 25/1,000 (66 infant deaths) in 1996, in 1997 decreased to 24.4/1000 (64 infant deaths) and in 1998 was 21.5/1000 (59 infant deaths). In assessing the rates over the last five years, there has been a definite downward trend. However, care must be taken in the interpretation of these data because of two factors: (1) the confidence level of the validity of the data being reported by the state statistics office for both live births and infant deaths are not high; and (2) the statistical anomaly of the small number problem where one event either way can change the rate dramatically. 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.

National Outcome Measure #2 - The ratio of the black infant mortality rate to the white infant mortality rate. *Annual Outcome Objective = NA*

National Outcome Measure #3 - The neonatal mortality rate per 1,000 live births. *Annual Outcome Objective for 1999 = 15.5/1000 live births.*

The Annual Outcome Indicator for the FSM for 1999 is 14.0/1000 live births. During 1999, there were a total of 33 neonatal deaths that were reported from the four states. See discussion for National Outcome Measure #1.

National Outcome Measure #4 - The postneonatal mortality rate per 1,000 live births. *Annual Outcome Objective for 1999 = 7.5/1000 live births.*

The Annual Outcome Indicator for the FSM for 1999 is 5.5/1000 live births. During 1999, there were a total of 13 postneonatal deaths that were reported from the four states. See discussion for National Outcome Measure #1.

National Outcome Measure #5 - The perinatal mortality rate per 1,000 live births. *Annual Outcome Objective = NA*

National Outcome Measure #6 - The child death rate per 100,000 children aged 1-14.

Annual Outcome Objective for 1999 = 18/100,000.

The Annual Outcome Indicator for the FSM for 1999 is 30.3/100,000 children aged 1-14. During 1999, the four states reported a total of 13 childhood mortalities between the ages of 1-14 out of a population of 42, 845 children 1-14 years of age based on the 1999 estimated projections of the 1994 Census. In 1998 there 30 deaths (70.1/100,000) in this age group and in 1997 there were 25 deaths (54.2/100,000) reported in this age group. Because of the small base population, it is difficult to determine whether this decrease in the number of child deaths is an actual decline in the number and rate for if this is due to under-reporting.

State Negotiated Outcome Measure #1 - The percent of 18 month old children with normal development.

Annual Outcome Objective for 1999 = 90%.

The Annual Outcome Indicator for the FSM for 1999 is 91.1%. This data reflects reports from Kosrae and Chuuk only - Yap and Pohnpei did not submit data. Of the 374 children that were screened in the well baby clinic, 341 had a normal developmental screen.

III REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

No materials included

3.1.1 Needs Assessment Process

Because of the need to coordinate the needs assessment process among the four states, the National MCH Program convened a major conference that brought together the MCH Coordinators and representatives from the Statistics and Data offices from the four states. The FSM-MCH Coordinators Workshop - Improving MCH Data Systems was conducted during January 24-28, 2000 at The Palikir in Pohnpei, FSM. The workshop was one of the major activities of the United States Maternal and Child Health Bureau's Year 2000 State Systems Development Initiative (SSDI) Project for the Federated States of Micronesia. The workshop included representatives from the National Government's Department of Health, Education, and Social Affairs, the State Coordinators of the Maternal and Child Health Programs and the State Statisticians from the four FSM States.

The goals and objectives of the workshop include: (1) Review the Title V MCH Block Grant needs assessment and grant application process for submission on July 15, 2000; (2) Review the SSDI Project implementation and outcomes for Year 2000 - 2001; (3) Introduce the components of an overall data system; (4) Define and discuss problems associated with data capture and data collection; (5) Facilitate the acquisition of MCH data for the needs assessment and for monitoring the Title V MCH indicators; (6) Provide training on the basic fundamentals of the EPI-INFO software program; and (7) Develop plans for future consultation visits during the year in the four states.

The data indicators for the needs assessment and the MCH grant application were identified and the data sources were selected for the indicators. The following data indicators were selected for each of the population groups: Pregnant women, mothers, and infants: Cervical cancer screening, early PNC, number PNC visits, high risk pregnancies (diabetes, anemia), Hepatitis B screening, birth weight distribution, infant mortality (NNM and PNM), breastfeeding at 6 months of age, hospitalization rates for infants (0-1) due to acute gastroenteritis (AGE), acute

respiratory infection (ARI), and malnutrition.

For the children and adolescent population: 2 year old immunization (24 months through 35 months) - includes Hepatitis, hospital rate (1 through 4) due to AGE, ARI (code ASTHMA), and malnutrition, hospital rate (1-14 years) due to injuries, hospital rate (1-14 years) injuries due to MV crashes, ER/OPD/Disp Encounters (1-14 years) due to AGE, ARI, injuries, child death rate (1-14) by principal cause, child death rate (1-14) due to MV crash, child death rate (1-14) due to injuries, DMF rates for children, percent third graders with protective sealants, teen births (15-17 year old), youth suicide (15-19 year old), death rate (15-24 year old) due to MV crashes, hospital discharge (15-24) due to MV crashes, rate of reported Chlamydia (15-19 years), rate of reported Chlamydia (20-44 years), percent adolescent (Grade 9-12) and tobacco product use in past month

For the children with special needs population: Total number of children registered, percent children based on diagnosis, percent children with completed assessment.

It was determined that the majority data should be available from the state statisticians (birth certificate, death certificate, OPD encounter, hospital discharge) and from the various programs within the public health services such as Family Planning Program, the Prenatal Care Program, the Immunization program, the Dental Division, School Health Services Program, and the STD Program. Data out of the Department of Health would be obtained from the Department of Education, the Headstart Program, and the Department of Public Safety.

3.1.2 Needs Assessment Content

No materials included

3.1.2.1 Overview of the MCH Population Health Status

Based on the 1999 estimated projections on the 1994 Census, the total population of the FSM stands at 113,032 residents. The distribution of the population among the four states shows that the state with the smallest population is the State of Kosrae with 7,691 residents (6.8% of FSM total); the next largest population is in the State of Yap with 11,856 persons (10.5% of FSM total); Pohnpei state has a total population of 36,146 (32% of FSM total); and the largest population is in the State of Chuuk with 57,339 residents (50.7% of FSM total). Of this total population of 113,032, there are 25,320 women of child-bearing years of 15-44, which is 22% of the total population. Of this total population of child-bearing age women, there are 4,030 women between the ages of 15-17 years.

PREGNANT WOMEN - During 1999, there were 2,365 women who were provided prenatal care and who delivered an infant. Of these 2,365 women, 99 were between 15-17 years of age. Of these women, only 230 (9.7%) received early prenatal care during this year. In 1997, 11% of the women received early care and in 1998, 20.3% received early care. This indicator has been traditionally low, however, this year appears to be the lowest percentage of women so far. In assessing the Health Status Indicator #3 that measures the number of women who receive at least 80% of their expected number of prenatal visits, 41% 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. When assessing the data to measure the full Kotelchuk Index for Adequacy of Prenatal Care Services and taking into consideration the early initiation of prenatal care and

the ratio of observed visits to expected visits, only 15% of the women have received “adequate” care, 9% have received “intermediate” care, and 76% received “inadequate” care.

The Chuuk State MCH Program has conducted a qualitative survey of 100 women who delivered at the hospital during 1999. Of these 100 women, 21% received early prenatal care and 79% received late prenatal care. The qualitative survey focused on questions to determine the types of barriers that the women faced that prevented them from receiving prenatal care. Of the surveyed, 45% reported that transportation to the clinic to receive services is a major problem, 25% reported that they were too busy with other children and other household chores to come to the clinic, and a small number reported that they worked. Another set of questions were focused on reasons why the women attended prenatal care. Of the women who responded to these questions, 50% reported that they wanted to know if the baby was healthy and 30% wanted to know about their own health status.

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 report 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 woman is in the labor room. It has been reported by the Chuuk MCH Coordinator and UNICEF Nutrition Advisor that previous undocumented studies of hematocrit levels of pregnant women in prenatal clinics show that approximately 50% of the women have a low hemoglobin that require treatment.

Other screening services, a Pap smear, Chlamydia screening, and screening for Hepatitis B, is part of the prenatal clinic services. Of the women who received prenatal care in 1999, 49.6% of the women who received prenatal care through the MCH Program received a Pap smear, 58.6% received a Hepatitis B screening during the pregnancy, and less than 10% of the women received a Chlamydia screen.

MOTHERS AND INFANTS - During 1999, there were 2,365 infants born, of which 7.1% were born with a low birth weight of less than 2,500 grams and 0.8% of the infants weighed less than 1,500 grams. Of these infants, there were 46 infants who died during the first year of life for an infant mortality rate (IMR) of 19.5/1000. The IMR varied widely among the four states with Kosrae having the highest rate at 31.7/1000; followed by Chuuk with 18.9/1000; Pohnpei State with 20.5/1000 and Yap having the lowest at 8.2/1000. In 1995, the infant mortality rate measured 23/1,000 (62 infant deaths), increased to 25/1,000 (66 infant deaths) in 1996, in 1997 decreased to 24.4/1000 (64 infant deaths) and in 1998 was 21.5/1000 (59 infant deaths). The IMR for 1999 represents a declining trend from 1995; 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, based on the 19 total infant deaths, 13 infants died in the neonatal period, of which six

infants were born prematurely and their deaths were attributed to complications of the prematurity. The remaining seven infants were born at term; and of these two infants had multiple congenital anomalies with anencephaly or hydrocephaly; and the one infant each died of the following causes: neonatal asphyxia, hydrops fetalis, disseminated intravascular coagulation, sudden infant death syndrome, and sepsis. The remaining six infants died in the period between 28 days and 364 days of life - the post neonatal period. All of these six infants died due to some form of infection - four with pneumonia, one with meningitis, and one with meningococemia. Of the four infants who dies with pneumonia, malnutrition was a complicating factor and most likely contributed to the death. In analyzing all of the infant deaths, it appears that the complications of prematurity continues to be the primary cause of death in the neonatal period. An additional complicating factor of high risk in five of the infant deaths was a young teen age mother, pregnancy with no antenatal care, and home deliveries. Of the infants who died in the post neonatal period, all were due to some form on infection with severe malnutrition as a complicating factor in two of the infant deaths. It is difficult to determine which of these infants deaths may have been prevented; however, it is probable that those neonatal mortalities with the complicating factors of a teen age mother, no antenatal care, and home delivery as well as the majority of the post neonatal deaths could have been prevented with appropriate preventive primary care services - including adequate prenatal care and nutrition education for the infants and children.

For Chuuk State, in reviewing the cause of death of infants in the neonatal period, five died from a possible infectious process, four of the infants were born premature, one born with multiple congenital anomalies, one died of SIDS, one of hemolysis of the newborn, one of asphyxia, and one of seizures. Of the five infants who died after 30 days of life, four died of an infectious process and one died at home of unknown causes after being born premature. In examining the two groups, it appears as if the two major causes of death in the infant period are infections (nine infants) and prematurity (four infants). 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.

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 the four FSM states, 99.9% of the infants who are discharged from the hospital are exclusively breastfeeding. However, by one month age there appears to be a decline in the number of exclusively breastfed infants and by six months of age, only 35.6% of the infants

Age	Pohnpei	Kosrae	Chuuk	Yap	Total	1 mo	2 mo	4 mo	6 mo	
						BF	80.1%	65.1%	31.8%	9.8%
						BF+Sup	15.8	28.7	49.2	52.3
						Form	3.2	4.1	7.6	6.8
0-5	4934	919	8322	1468	15643	Form+Sup		2.1	7.6	9.1
6-10	4850	889	8086	1437	15262	Food			1.5	1.5
11-14	4607	1057	7924	1435	15023	BF+Food			2.3	12.9
15-19	4166	987	7085	1394	13632	Form+Food				5.3
Total	18557	3852	31417	5734	59560	All three				2.3

Child Population by Age Group and State, 1999

BF=Breastfeeding Sup=Supplement Form=Formula

are exclusively breastfeeding. Data collected at the Well

Baby Clinics in Yap State show that at one month age 80% of the infants are breastfeeding with 15% being supplemented with the juice from young coconuts or water. At 2 months of age 65% of the infants are exclusively breastfeeding and the percentage of infants being supplemented with water has doubled. So, in Yap State, by 6 months of age only 9.8% of the infants are exclusively breastfeeding and over half are being supplemented, approximately 16% are being given formula and 22% are being given solid foods.

CHILDREN AND ADOLESCENTS - According to the 1999 projected population estimates based on the 1994 Census, there are 59,560 persons between the age of 0 through 20 years which comprises 52.7% of the total population in the FSM. Of this population of persons under 20 years of age, 45,928 are 14 years old and under and 13,632 are between 15 and 19 years of age. The population in the FSM is a relatively young population where 41% 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 October to December in 1999, the data from the ER/OPD reveals a total of 7892 encounters for children in the 1-14 year old age group. Of these children 1244 visits were for acute respiratory infections, 795 for acute gastroenteritis, 137 for visits related to injury, and 83 visits for asthma. During the same time period, there were 146 children between the ages of 0-24 years who were admitted to the hospital. Of these, 75 admissions were to infants under one year of age of which 10 were for acute gastroenteritis, 65 for acute respiratory infection, and none for malnutrition. In the 1-4 year age range there were 56 children of which 44 were for acute respiratory infection, 11 for acute gastroenteritis, and one for malnutrition. There were 15 children between 1-24 years of age who were admitted for injuries due to motor vehicle accidents.

In Kosrae, in the infant age group (0-1 years) the most common reasons for hospitalizations were 57.4% for acute respiratory infection, 35.6% for anemia, 4% for acute gastroenteritis, 3% for malnutrition and poor development. In the 1 to 4 year age group the leading causes of hospitalization are acute respiratory infection (36%), anemia (28%), asthma (14%) and gastrointestinal disturbance (10%). The most common diagnoses for outpatient visits include skin disease (scabies and impetigo) and otitis media. For the older children 5-14 years of age the causes for hospitalization include 64% for acute respiratory infection, 11% for GI disturbance, and 3% for injuries.

Dental disease among children remains one of the major public health problems in all four states of the

Federated States of Micronesia. Dental surveys and studies dating back to 1986 have consistently shown that selected populations of young children in the Headstart Programs in the FSM had high prevalence rates of dental disease and minimal access to dental care. In 1991, a subsequent study of dental resources showed that for the four FSM states, there were four Dental Officers, 25 Dental nurses, and 9 Dental Assistants. Since that time, little has changed in the availability of and access to dental services for children. Recent dental surveys conducted in Kosrae State and Chuuk State continues to show high prevalence of dental disease among the children in the FSM.

In Chuuk State, Dr. T.H. Aye, Dental Health Officer for the Department of Health Services conducted an oral health status survey in 1996-1997 academic year. He examined a total of 427 children between the ages of 3-5 years in various Headstart Programs on the Island of Weno, other Lagoon Islands, and Outer Islands in the State of Chuuk. This selected population represented 50% of the total enrollment in the Headstart Programs during that academic year. His findings showed that the prevalence of dental cavities ranged from 71% in the Outer Islands, to 78% in the Lagoon Islands, and 85% on Weno. The mean dmf values also followed the same pattern with the highest values on Weno at 5.2, followed by the Lagoon Islands at 4.4 and the lowest in the Outer Islands at 4.0. Further discussion revealed that these values were most representative of diseased teeth with missing and filled teeth at almost zero values.

In Kosrae State, Dr. M. Takagaki, DDS, from a volunteer agency in Japan, conducted dental examinations of all the elementary school children in Kosrae state between October 1998 and February 1999. A total of 1883 children in seven schools from preschool to grade nine were examined. The study appears to document prevalence rates only for each of the individual schools by individual grades. The lowest prevalence of DMF was measured at the SDA Elementary School where 55 students were examined with a prevalence of 58%. Four schools had a prevalence of 79%, two schools with 84%, and one school with 93% prevalence.

Vitamin A deficiency and iron deficiency anemia is an emerging major health problem that is becoming more evident in the child population in Kosrae and Yap states. At the request of the FSM Government, a survey 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.

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 562 children registered in the CSN data base in the four FSM states. These are children who have been screened by various community programs, referred to the CSN Program, have a completed assessment or in the process of receiving an assessment. The CSN is

based on an interdisciplinary model that uses a team made up of representatives from the Special Education Program, the Headstart Program, the Public Health Nurse, the physical therapist, the nutritionist, and the 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 who 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. There are no pediatric neurologists, developmental pediatricians, pediatric ophthalmologists, occupational therapists, audiologists, nor pediatric nutritionist with specialized training in serving children with special needs.

3.1.2.2 and 3.1.2.3 Direct Health Care Services and Enabling Services

The priority concerns for direct health care and enabling services are: (1) the improving of timely and continuous prenatal care services for all pregnant women, (2) the continuation of the well baby clinic services for infants and young children, (3) improving the rates for exclusive breastfeeding for the first six months of age; (4) primary health care services for children, (5) transportation services for women to attend prenatal clinics and well baby clinics, (6) outreach services to assure that the populations in the outer islands have access to primary direct health care services. The resources to provide these direct services for prenatal care and well baby care are limited, however, are sufficient to be able to provide only the primary level of care at the central public health clinic site as well as some the community-based sites in most states. Those states with a large number of outer islands - such as Chuuk State and Yap State - will have difficulty in providing even the primary level of these basic services to those residents on the outer islands.

The Kotelchuk Index for Adequacy of Prenatal Care shows that about 80% of the women in the FSM are receiving inadequate because of late initiation of prenatal care coupled with a lower ratio of observed to expected number of visits. This high rate of inadequate care may reflect on the high infant mortality rate and high morbidity rates due to acute infections found among infants and young children. There is a need to improve the outreach program to assure that pregnant women initiate care early and receive continuous prenatal care one it has been initiated.

The rates of infants exclusively breastfeeding at six months of age is only 35% in the four states. This low figure is despite the fact that almost 100% of the infants are discharged from the hospital while breastfeeding. Kosrae and Yap states have a higher percentage of infants breastfeeding at six months and these two states also have implemented a community based program of older women who provide breastfeeding education and support. There

is a need to assess this model and implement it for the other two states.

The availability of direct health care services is limited for all populations and is especially acute for children with special needs. In the FSM, there is a lack of specialty trained health and medical personnel such as pediatric specialists, dentists, physical therapist and nutritionists trained to work with children with special needs, occupational therapist, audiologist, and speech and language therapist.

The FSM does not have a Medicaid Program nor a welfare program, so there is no impact of shifts in coverage of these two programs on the MCH population. The unique situation in the FSM is that the state governments assures that direct medical and health services are provided to all residents of the state regardless of ability to pay for these services. The National FSM does have a health insurance program, however, only employees of the government are eligible for the insurance plan. With the constraints in the National and State budgets, some elements of these direct health services are being curtailed and the services that are being primarily affected are pharmaceuticals and medications, off-island medical referrals, and occasionally laboratory services.

3.1.2.4 Population-Based Services

The FSM does not have a Newborn Metabolic Screening Program, a Newborn Hearing Screening Program, SIDS Counseling Services, a Birth Defects Surveillance Program, an Injury Prevention Program, or a Lead Screening Program.

The Immunization Program in each of the four states is funded by the U.S. Centers for Disease Control and Prevention which provides funds for personnel, equipment, travel, supplies, and vaccines. The MCH Program staff work closely with the Immunization Program staff to assure that immunizations are provided to infants and young children in the well baby clinics and to the older children in the School Health Services Program. The MCH Program and Immunization Program staff work together to on outreach field trips assure that immunizations are provided to all children living in remote areas. There is a need to continue these services and to assure that more outreach services are provided.

Screening services for pregnant and post-partum women include Pap smear screening, Chlamydia screening, STD screening, and Hepatitis B screening. These services are primarily provided in the prenatal clinics and use a variety of funding sources to purchase the equipment and supplies needed. The Pap smear kits are purchased with Title V funds, while the supplies for Chlamydia screening and STD screening are from the STD Program and the reagents for the Hepatitis B screen is purchased by the Immunization Program. 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 to the pregnant women population.

With the recent survey data that is showing that a large proportion of young women of child-bearing age and children may be anemic, hematocrit screening of all pregnant women and of infants between 9 and 12 months of age is a critical service to identify those who are anemic and require treatment. In addition a comprehensive nutrition education program for improving the overall nutritional status of young women, pregnant women, and children should be undertaken with an emphasis on foods that contain high iron and high Vitamin A. The MCH Program should coordinate with the staff who provide the prenatal care services, the physicians, and the community based

nutrition programs to develop this nutrition education service.

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.

3.1.2.5 Infrastructure building Services

The existing system of services in the four FSM states is currently based on a centralized hospital based medical and health care delivery system. Because of the enormous costs of curative hospital based care, the states are planning and developing a de-centralized system of care that utilizes community-based dispensaries and sites for the provision of primary preventive health care services. In order to achieve this community based system of care, the collaboration among the public health sector and the acute care hospital based sector will need to be established. For pregnant women, mothers, and infants collaboration among the MCH staff, the staff that provides family planning and prenatal care services, the Immunization Program staff, and health educator need to work together to assure that the full complement of services for this population is provided. For services to children, the collaboration that needs to be established include the MCH program, the Immunization Program, the School Health Services Program, and the hospital staff. For Children with Special Needs, the collaboration among the hospital staff physician and physical therapist, the Special Education Program staff, the Headstart Program staff will need to be continued. To promote the development of comprehensive systems of services, there is a need for the development of consistent policy and procedures, common definitions of services, common data reporting mechanisms, technical assistance and training at the state levels, which should be provided by the State Agency (National MCH Program) level.

The FSM does not participate in the following Federal programs: Medicaid, Supplemental Security Income (SSI) Program, Ryan White Program, social services programs, Part C of IDEA, the Child and Adolescent Services Systems Program (CASSP), State interagency transition program, developmental disabilities programs, or the WIC Program. An interagency agreement does exist between the MCH Program's Children with Special Needs Program and the Department of Education's Special Education Program.

For children with special needs, the constructs of the service system is established through the community-based Interagency Council within each state. This council is made of representatives from the public health programs, the Department of Education, the Headstart Program, and the parent network. These interagency councils maintain the process for facilitating community systems building, and coordination of health and education services for children with handicapping conditions.

The State's efforts in the development and implementation of guidelines and standards of care during 1999 has been the development of the Well Baby Clinic services which include the following components: (1) Parent

interview - Well Baby Clinic services should start with a parent interview and focus on asking the appropriate "trigger questions" that may elicit indicators of problems or issues that will need to be addressed with education and counseling. These questions should be developmentally appropriate and may be related to breastfeeding, concerns related to feeding issues, sleeping patterns, acute illness, and concerns related to mother's health, or other concerns in the family. A nutritional assessment should be conducted to determine the nutritional intake of the infant or child.

(2) Growth measurements - Measurements should be taken at each Well Baby Clinic and Well Child Clinic visit and should include weight and height/length, as well as head circumference measurements (for first year of life). The measurements should be plotted on the appropriate growth curve to determine the percentile of growth in each of the parameters. The health care provider should also interpret the measurements and growth patterns of the infant or child to the parent. If the child is growing well, the parent should be commended and encouraged to continue.

(3) Immunizations - Immunizations are a primary service provided at Well Baby Clinics. Education and counseling should be provided to the caregivers about the importance of periodic visits to assure that the immunization series is completed at the appropriate ages.

(4) Developmental screening - Developmental screening, along with screening for appropriate growth, is one of the most important indicators that can indicate whether an infant is doing well. Developmental screening must be age appropriate and should be conducted at each Well Baby Clinic visit. Infants and children who are suspected of having delays in their development should be referred to the Children with Special Needs Program for a comprehensive assessment.

(5) Hematocrit screening - Because the infant is at the highest risk of developing iron deficiency anemia between 9-12 months of age, screening of the blood for hemoglobin/hematocrit should be conducted at this age. If the hemoglobin or hematocrit is low, then a full dietary history should be obtained to determine the level of iron intake. If the dietary history indicates low iron intake, then nutritional counseling and iron therapy should be instituted with appropriate follow-up.

(6) Education and counseling - Because of the emphasis on prevention and anticipatory guidance in well baby care, developmentally appropriate education and counseling services are critical for caregivers. Some of the topics that should be covered include: the importance of continuous well baby care, normal developmental progression of infants and children, nutrition and feeding, supplemental vitamins and fluoride, brushing teeth, immunization, recognizing early signs of illness (fever, failure to eat, vomiting, diarrhea, dehydration, skin problems), handling common illness, discipline, safety and injury, and appropriate parent-child interactions.

(7) Physical examination - A physical examination should be performed by the MCH Public Health Nurse as a method of screening for physical or medical problems. A physician should be available for referral and consultation for any questionable findings. The physical examination, though thought to be the most important activity is only a small portion of the Well Baby Clinic visit.

(8) Outreach services - Outreach services can be defined as those activities undertaken to identify individuals who should be receiving a service, to contact the individuals, and to extend services to assure that services are received. For the well baby and well child system of services, the names of infants and children who are attending the well care services are compared to the list of names obtained from the newborn registry to ascertain whether all the infants that should be attending the Well Baby Clinic are in fact being provided services. Those infants whose names are on the newborn registry and who are not receiving Well Baby Clinic services should be provided with outreach services

to assure that infants are seen. Outreach services may include sending postcards, telephone calls to the home, or a home visit.

3.2 Health Status Indicators

See Supporting Documents Section 5.4 through Section 5.7

3.2.1 Priority Needs

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. The assessment of services for pregnant women shows that only 9.7% of the women received early prenatal care, a decline from 1997 and 1998 when 11% and 20.3% received early care respectively. For those women who do initiate care, only 15% receive adequate care, 9% receive intermediate care, and 76% 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 50% 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.

Of the infants born in 1999, 7.1% were low birth weight, 0.8% were very low birth weight and 46 infants died for an infant mortality rate of 19.5/1000 which is a decline from the 1998 IMR of 21.5/1000, the 1997 IMR of 24.4/1000, the 1996 IMR of 25/1000, and the 1995 IMR of 23/1000. 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 infections 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.

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. Recent surveys have shown that in one state 57% of the children were Vitamin A deficient and 13% had low hemoglobin; while in another state the Vitamin deficiency rate among children was 38% and 11% had low hemoglobin. Currently two of the four states have Vitamin A supplementation programs and these data indicate the need for supplementation programs in the two additional states. 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 and lack of child care. 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.

The FSM has adopted the WHO policy of exclusive breastfeeding of infants for the first six months of life. The data shows that 99.9% of the infants are breastfed at discharge from the hospital, but at 6 months of age that percentage decreases to 35%. The two states that have the highest percentages of infants breastfeeding at six months of age also have implemented a community-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.

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.

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 2,000 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 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, 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. There is an need to develop an alternative model of providing care to this population. With the advances in computer and communications technology, one model that may be developed is the real time on-line team consultation model using the existing telehealth systems between the CSHCN teams in the FSM and a CSHCN team in Hawaii.

Based on the findings in the MCH needs assessment, the Health Status Indicators, and other data, the FSM's priority needs include:

1. To increase the percentage of women receiving adequate prenatal care.
2. To improve the nutritional status of women during their pregnancy.
3. To decrease infant mortality rate.
4. To increase the percentage of infants exclusively breastfeeding at 6 months of age.
5. To decrease dental disease among children.
6. To improve the nutritional status of children.
- 7..To decrease the percentages of acute infectious illnesses among children
8. To increase the percentage of children with special needs served by a team.

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

The following table is a summary of the budget request for FY 2001. The Administrative costs and the CSN Component will be retained at the National Government's MCH Program and distributed to the four states as appropriate. The budget for each of the states will be used for accomplishing the performance and outcome measure for pregnant women, mothers, infants, and children.

	Administ	CSN	Preg/Mother	Child/Adol	TOTAL
Personnel	\$14,610	\$39,036	\$94,901	\$94,902	\$243,449
Fringe benefit	\$731	\$2,342	\$5,260	\$5,261	\$13,594
Travel	\$19,000	\$42,000	\$8,980	\$37,620	\$107,600

Equipment	\$3,750	\$3,469	\$0	\$19,500	\$26,719
Supplies	\$4,000	\$46,858	\$9,245	\$14,613	\$74,716
Contract	\$1,000	\$23,650	\$28,640	\$0	\$53,290
Other	\$8,366	\$24,650	\$5,413	\$5,414	\$43,843
TOTAL	\$51,457	\$182,005	\$152,439	\$177,310	\$563,211
Percent	9.14%	32.31%	27.07%	31.48%	100%

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2001

As documented in the Statement of Assurances in *Section III, REQUIREMENTS FOR APPLICATION*, the Federated States of Micronesia assures the Secretary of DHHS that **no more than 10% of funds will be used for administrative costs of each program component**. The FSM further assures the Secretary that it defines these administrative costs as the salary for the MCH Financial Management Specialist, fringe benefits, travel for the Financial Management Specialist and the National MCH Program Specialist and expendable supplies to support the administration of the program at the National Government.

PERSONNEL \$14,610

A total of \$14,610 is budgeted for personnel cost and includes provision of within-grade increase for the MCH Financial Management Specialist currently funded by MCH funds.

FRINGE BENEFITS \$731

A total of \$731 has been set aside for fringe benefits which cover social security, insurance and other benefits due the staff. Fringe benefits are based at 5.0% of the total base salary.

TRAVEL \$19,000

A total of \$19,000 has been budgeted to fund three (3) persons (National MCH Program Specialist, MCH Financial Management Specialist and Finance Federal Grants Manager) on one trip to Kosrae, Chuuk and Yap for a total of three round trips. Purpose of these trips is to conduct on-site monitoring of fiscal and program matters with the state counterparts to determine the progress of achieving activities aimed at accomplishing the objectives of the program for FY 2001, and for fiscal monitoring of program funds. The budget also includes a trip for the MCH Program Specialist and the MCH Financial Management Specialist to San Francisco for the review of the MCH Block Grant Application for FY-2002.

EQUIPMENT \$3,750

This amount is requested to purchase one copier machine to be used at the National Government. To print copies of important communication from MCH Bureau and training documents for the MCH Program.

SUPPLIES AND MATERIALS (EXPENDABLE) \$4,000

The amount of \$4,000 is requested in FY 2001 to purchase expendable supplies and materials necessary to maintain the administrative operation of the program at the National level. Examples of these include computer papers, diskettes, papers, pens, computer toners, pencils, file folders, portfolios, etc.

CONTRACTUAL \$1,000

A total of \$1,000 is requested to cover the cost of maintenance and repair of such equipment as vehicle, copying machines, typewriters, computers, etc.

OTHER \$ 8,366

a. Communication: \$3,500

A sum of \$3,500 is requested to cover telephone calls (overseas), dispatches, telexes, facsimile (FAX), e-mail and other forms of communication outside of Pohnpei (seat of the FSM National Government) that relate to MCH program.

b. Printing & Reproduction: \$1,000

This amount is to cover costs of printing and reproducing reports, correspondence, and materials that are MCH-related and need to be reproduced/duplicated in multiple copies for the states. Some of the forms, such as growth charts, 844 Forms and Prenatal Clinic Forms (revised) may need to be printed on Pohnpei as some of the states do not have printing shops.

c. Membership Dues: \$1,050

This amount is to cover the FSM annual membership fees to the Association of Maternal and Child Health Programs (AMCHP) and other program related associations.

d. Freight: \$2,816

The amount of \$2,816 is requested for freight to assist in sending supplies to the three states of Chuuk, Kosrae and Yap. Examples of these are oral rehydration solutions (ORS) donated by UNICEF to the FSM Government, other medical supplies like Abendazole and Benzathine (long-acting Bicillin) are purchased in bulk by the FSM National Government in order to reduce cost and sent to the states.

TOTAL: \$ 51,457

PREGNANT WOMEN, MOTHERS & INFANTS (27.6%)
BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2001

PERSONNEL \$ 94,901

The sum of \$94,901 has been budgeted for 17.5 FTE personnel and includes provision for within-grade increases for staff at each of the four (4) States of Kosrae, Chuuk, Pohnpei and Yap.

FRINGE BENEFITS \$5,260

A sum of \$5,260 has been set aside for fringe benefits which cover social security, insurance and other benefit due the staff. Fringe benefits are based on an average of 6.0% of the total base salary. Kosrae has the highest fringe benefit rate of 7.0% compared to Pohnpei at 6.0% and 5.0% for FSM National Government.

TRAVEL \$8,700

Travel cost includes staff travel to the outer islands and the lagoon islands, off-island trips related to MCH conferences, workshops or training. The frequency of these interstate or intra-state travel varies from state to state. However, for inter-state travel, no less than one trip per year will be made to provide and update immunization;

family planning information, education and counseling (IEC) and contraceptives; nutrition education and counseling; basic prenatal care and well baby care (including promotion of breast-feeding and growth monitoring). Health education to address various STD topics, including HIV/AIDS and Hepatitis B, will be part of staff presentations to the service population in the lagoon and outer islands.

SUPPLIES \$9,245

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

CONTRACTUAL SERVICES \$28,640

This amount is for a contract with the Cytology Laboratory of Hawaii in Hilo to provide Pap Smear Kits and Pap smear readings for the four (4) States for the year. In FY 2001, the MCH Program at the National Government will submit one contract for the four (4) State MCH Programs and the Cytology Laboratory of Hawaii for Pap smear kits and readings. CLH will send Pap smear kits to each State MCH Coordinator. Pap smears will be sent to CLH in Hilo, Hawaii for reading and results will be faxed to a dedicated fax machine located at each State Public Health.

OTHER \$ 5,413

This amount requested for FY-2001 is to cover the cost of printing and reproducing MCH educational materials, correspondence, reports; communication (telephone, FAX,); freight and petroleum, oil and lubricant (POL)

TOTAL: \$ 152,439

CHILDREN & ADOLESCENTS (32.1%)

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2001

PERSONNEL \$94,902

This sum has been budgeted for 17.4 FTE personnel and includes the provision of within-grade increases for staff at each of the four (4) State of Kosrae, Chuuk, Pohnpei and Yap.

FRINGE BENEFITS \$5,261

A sum of \$5,261 is set aside for social security and other benefits due the staff. Fringe benefits are based on an average 6.0% of the total base salary.

TRAVEL \$37,620

A total of \$37,620 is budgeted to cover the travel cost. Travel cost includes staff travel to the outer islands and the lagoon islands. The frequency of these inter-state or intra-state travel will vary from state to state. However, for inter-state travel, no less than one trip per year will be made to provide immunization, family planning counseling and contraceptives, nutrition education and counseling, basic prenatal care (teenage mothers) and/or well baby care. Health education to address various STD topics, including HIV and Hepatitis B infection will be part of staff presentations to the service population in the lagoon and outer islands.

EQUIPMENT \$19,500

This amount is requested for the purchase of two portable dental units, air compressors, and portable lamps for the dental unit to provide protective sealants in the schools. Also budgeted are four pediatric examination tables with

scales and length measuring for the well baby clinics.

SUPPLIES \$14,613

This amount is to purchase both office and medical supplies for the four (4) States of Chuuk, Kosrae, Pohnpei and Yap. The increase under this expense category is to accommodate the dental supplies needed to conduct a dental survey in FY 2001 in order to develop the capacity of each state to adequately address the oral health problems, especially of the children in the Headstart programs.

OTHER \$5,414

A total of \$5,414 is requested to accommodate the costs of printing and reproduction, communication, freight, fuel, oil and lubricant for Chuuk, Kosrae, Pohnpei and Yap.

TOTAL: \$177,310

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (31.1%)

BUDGET NARRATIVE JUSTIFICATION - Fiscal Year 2001

PERSONNEL \$39,036

A total of \$39,036 is budgeted for personnel cost for Chuuk MCH Coordinator, CSHCN Coordinators for Pohnpei and Kosrae and also the National Federal Program Coordinator detailed in Chuuk State.

FRINGE BENEFITS \$2,342

This amount covers the social security, insurance and other benefits due the staff, and is based on an average 6.0% of the total base salary.

TRAVEL \$42,000

Justification for the \$42,000 in travel cost for this category, including information related to the pediatric cardiology team. The budget breakdown of the \$42,000 follows:

Traveler	Destination	Airfare	Car Rental	Per Diem	Total
1. Dr. Singer	LA/Hon/4 state/ret	1,795	1,125	2,435	5,355
2. J. Benjamin	PNI/Palau/ret	800	520	952	2,272
3. I. Edward	Pni/Palau/ret	800	520	952	2,272
4. R. Reynold	Kos/Palau/ret.	745	520	952	2,217
5. A. Gaamed	Yap/Palau/ret	1,350	520	952	2,822
6. A. Meyshine	Chk/Palau/ret	1,050	520	952	2,522
7. J. Benjamin	Pni/Palau/ret	800	520	952	2,272
8. I. Edward	Pni/Palau/ret.	800	520	952	2,272
9. A. Meyshine	Chk/Palau/ret	1,050	520	952	2,522
10. R. Reynold	Kos/Palau/ret.	745	520	952	2,217
11. A. Gaamed	Yap/Palau/ret	1,350	520	952	2,822

12 CSHCN Parent	Pon/Palau/ret	800	520	952	2,272
13. CSHCN Parent	Kos/Palau/ret.	745	520	952	,217
14. CSHCN Parent	Chk/Palau/ret.	1,050	520	952	2,522
15. CSHCN Parent	Yap/Palau/ret.	1,350	520	952	2,822
Subtotal		15,230	8,405	15,763	39,398
Adjustment					2,602
TOTAL					42,000

Travel Narrative Justification:

1. Dr. Singer will continue to provide on-site pediatric consultant services to all four states in FY 2001. He will be contracted to re-evaluate 300 children and adolescents with cardiac problems;

2-5. MCH Coordinators from the National Government, Kosrae, Pohnpei and Yap are assured travel funding to the April 2001 MCH Institute in Palau;

6-11. MCH Coordinators (National Government & four states) to the 2001 Pacific Basin Interagency Leadership Conference to be held in Palau; and

12-15. One CSHCN parent representative from each states to the March 2001 Pacific Basin Interagency Leadership Conference. A portion of this travel money will also fund the trips of the MCH Program Specialist, MCH Financial Management Specialist and the MCH Consultant to travel to the four states in the FSM.

SUPPLIES \$46,858

a. Expendable/Consumable \$3,000

A total of \$3,000 is requested for expendable/consumable supplies for the four (4) states for operating and managing activities related to preventive and primary care services for children with special health care needs. This amount will also be used by all four states in supporting inter-agency council activities to promote and strengthen systems development for children and their families.

b. Medical & Dental Supplies: \$43,858

A sum of \$43,858 is requested to purchase long acting Bicillin from either the JPA Wholesalers on Guam or Perry Point, Maryland, for children and adolescents under age 22 who are receiving this prophylactic every month; Albendazole to be purchased from a pharmaceutical company in Australia to deworm all children above two years old through 21; and DPT to support the immunization program. DPT vaccine is not part of the '**direct assistance**' provided by the Centers for Disease Control to the Federated States of Micronesia's Childhood Immunization Program. All other vaccines are provided to the Immunization Program through the direct assistance program from the Centers for Disease Control. DPT was initially not included in the list of vaccines provided by CDC since the United Nations Children's Fund (UNICEF) provided to FSM without cost. However, several years ago, UNICEF advised the FSM Government that it could no longer afford to provide DPT free of charge to FSM but

that it will continue to assist in its procurement through the UNIPAC in Copenhagen at a much reduced cost. Annually, FSM requires 30,000 doses of DPT at \$7,500. Some of the preventive dental supplies, such as protective sealants, will also be purchased using funds under this project component.

EQUIPMENT \$3,469

A total sum of \$3,469 is requested to purchase one (1) lab top computer and a color printer to be use for the National MCH/CSHCN Program Specialist.

CONTRACTUAL SERVICES (CONSULTANTS) \$23,650

A total of \$10,000 is budgeted to accommodate the professional service fee of Dr. Melville Singer, independent Pediatric Cardiologist, estimated at \$10,000. The additional \$10,000 is requested to cover the cost of One Special Service Contract for a Data person to be located at the National Government. The remaining of \$3,650 will be expended for defraying the costs to parents to attend the Chuuk Parent Support Group Meeting. This group included parents of children with special needs. This meeting will invite parents from the outer and lagoon islands of Chuuk State to come to Weno for an annual meeting.

Consultant Fee and other:

a.	\$500 X 20 days/cardiologist:	\$10,000;
b.	Data Analyst	\$10,000
c.	Parents Support Groups Allowance	<u>\$ 3,650</u>
	Total:	\$23,650

OTHER \$ 24,650

Items included in the "Other" budget category for Component C.

<u>Object Class</u>	<u>Chuuk</u>	<u>Kosrae</u>	<u>Pohnpei</u>	<u>Yap</u>	<u>Total</u>
Communication	\$ 1,500	\$ 1,450	\$ 1,000	\$ 1,000	\$ 5,450
Supplies	\$ 1,800	\$ 1,500	\$ 2,000	\$ 1,500	\$ 6,800
POL*	\$ 2,200	\$ 1,000	\$ 2,200	\$ 1,000	\$ 6,400
Printing	<u>\$ 2,000</u>	<u>\$ 1,000</u>	<u>\$ 2,000</u>	<u>\$ 1,000</u>	<u>\$ 6,000</u>
Totals:	<u>\$ 7,500</u>	<u>\$ 4,950</u>	<u>\$ 7,700</u>	<u>\$ 4,500</u>	<u>\$24,650</u>

*POL - petroleum, oil, & lubricant.

The requested \$24,650 will be used for printing and reproduction, equipment repair services, freight, communication to pay for telephone calls (overseas), telexes, dispatches, facsimile (FAX), and other types of communication within and outside of FSM regarding this program component. This amount will be divided among the four (4) states depending on proposal submissions to the National Government. This amount will also support the activities of the interagency councils in each state to promote systems development for children and their families that are comprehensive, family-centered and community-based.

TOTAL: \$ 172,005

Object Class	Chuuk	Kosrae	Pohnpei	Yap	Total
Personnel	\$69,962	\$21,941	\$59,128	\$38,772	\$189,803
Fringe benefit	\$3,498	\$1,536	\$3,548	\$1,939	\$10,521
Travel	\$12,000	\$9,000	\$16,100	\$9,500	\$46,600
Equipment	\$3,500	\$4,500	\$7,000	\$4,500	\$19,500
Supplies	\$7,800	\$3,500	\$9,558	\$3,000	\$23,858
Contract	\$11,000	\$5,540	\$10,000	\$2,100	\$28,640
Other	\$5,200	\$2,750	\$1,676	\$1,201	\$10,827
TOTAL	\$112,960	\$48,767	\$107,010	\$61,012	\$329,749

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2001

State of Chuuk

PERSONNEL \$69,962

A total of \$69,962 is requested to pay the salary of two (2) graduate nurses, three (3) practical nurses, five (5) Health Assistants, one (1) health educator, one (1) MCH clerk typist and one (1) data entry clerk. This amount includes provision for within-grade increases for personnel who will be eligible for increment increases during Fiscal Year 2001.

FRINGE BENEFITS \$3,498

To cover the social security, insurance and other benefits due the staff, a total of \$3,498 is budgeted and based at 5.0% of the total base salary.

TRAVEL \$12,000

A sum of \$5,000 is requested to cover travel for nurses to continue field visits to the Outer-islands and five (5) nurses continue field visits in the lagoon islands.

A sum of \$2,000 is requested to use for allowance for parents of CSHN to come to the Center for the Parents Support Group.

A total of \$5,000 is requested to accommodate airfare and per diem for the MCH Coordinator and other MCH staff to attend off-island related conference, workshops or training. These meeting include the MCH institute sponsored by the regional office, San Francisco, MCH Coordinator meeting and other MCH related off island workshop.

EQUIPMENT \$3,500

This amount is requested to purchase one portable dental unit, portable air compressor, and portable lamp for the Division of Dental Health Services to provide protective sealants for third grade children in the schools.

SUPPLIES \$7,800

a) Medical and Dental Supplies \$6,500

Of this amount \$3,500 is to buy pre-natal medical supplies including prenatal tablets, iron tablets and liquid, multi-vitamins and Temptra for children and laboratory supplies. The remaining \$3,000 is requested to support the Dental Health Program to purchase toothbrushes, disclosure tablets, fluoride drops and sealants.

b) Office supplies (Expendable) \$1,300

A total of \$1,300 is requested to purchase office supplies to run MCH Clinic both in the center and out in the fields.

CONTRACTUAL SERVICES \$11,000

A total amount of \$11,000 is requested for contractual services. Of this amount, \$10,000 will be used to cover Pap smear costs for an estimated 990 women at a price of \$10.10 per Pap smear. The remaining \$1,000 will be used for repair/ and maintenance of equipment such as vehicles, air conditioner, typewriters.

OTHER \$5,200

a) Printing and Reproduction \$500

A sum of \$500 needed for printing and reproducing forms and MCH related materials.

b) Communication \$1,000

A sum of \$ 1,000 is requested to pay for overseas calls, Fax, e-mail, and telephone.

c) Petroleum Oil and Lubricant \$1,500

\$1,500 is needed to purchase gasoline and oil to conduct outreach services.

d) Boat Rental \$2,500

A sum of \$2,500 is requested to rent boats to go out in the field to conduct MCH outreach services such as prenatal and nutrition education to the mothers and caretakers, and to provide dental services to the schools outside the Lagoon.

e) Freight Cost \$500

A sum of \$500 is needed for sending the Pap smear to be read by outside Lab expert.

TOTAL: \$112,960

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2001

State of Kosrae

PERSONNEL \$21,941

This amount is requested for personnel and includes within-grade increases for four (4) full-time employees, four (4) health assistants and one (1) new position. Most of the MCH services have been decentralized to the four (4) villages of Kosrae to expand coverage of the MCH basic services.

FRINGE BENEFITS \$1,536

The above sum has been set aside for fringe benefits for the positions and includes coverage for social security, insurance and other benefits. This amount is based at Kosrae's new fringe benefit rate of 7.0% which went into effect in FY 1996.

TRAVEL \$9,000

This amount requested is to cover the cost of travel anticipated for fiscal year 2001. This amount also accommodates the cost for airfare and per diem for the MCH Coordinator, other appropriate staff and/or the Director of Health Services and/or his designee, to attend off-island MCH-related conferences, workshops or training.

EQUIPMENT \$4,500

This amount is requested to purchase 3 stretchable lamps for pelvic examinations, two (2) hemoglobinometers for the mobile clinics, two (2) fetoscopes for mobile clinic and central clinic and 2 pediatric stethoscopes.

SUPPLIES \$3,500

a) Medical & Dental Supplies: \$3,000

Of this amount, \$1,500 is requested to cover cost of pre-natal vitamins, iron tablets and liquid multi-Vitamin drops for children; and Tylenol or Tempra liquid for the Immunization Program. The balance of \$1,500 is to support the dental unit for its dental preventive medical supplies. This amount can purchase enough preventive supplies for MCH-client related medical supplies.

b) Expendable Supplies: \$500

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

CONTRACTUAL SERVICES \$ \$5,540

a) PAP smear costs: \$5,000

Kosrae began using the Cytology Laboratory of Hawaii in 1998. It will draw up a third year's contract with the same laboratory in FY 2000 for Pap smear readings. CLH will send Pap-kits to each State MCH Coordinator. Pap smears are sent to CLH for reading and results will be faxed to a dedicated fax machine located at each State Public Health. At a cost of \$10.10 for reading one Pap slide, this amount is enough to accommodate 495 Pap smears for all pre-natal first visits, post-partum first visits (two weeks/two months post-partum), Ob/Gyn and family planning clients.

A total of \$540 is requested for repair/maintenance of program equipment such as, vehicle, air condition, typewriter and other equipment needed for the MCH Program.

OTHER \$2,750

a) Printing & Reproduction: \$500

This amount of \$500 is requested for printing and reproducing health education materials

in both English and Kosraean for the MCH program. The printing expenses will include all clinic forms, educational pamphlets and instructional forms. Materials are also to be used for the community outreach education activities.

b) Communication: \$750

This amount is to cover the cost of communication both for long distance calls and the use of phones for the MCH Program.

c) Boat Rental: \$500

The above amount is for boat rental to use once a month with other programs going to Walung. The boat rental will take staff to Walung to provide health teaching, update immunization, physical examinations to school children and all the MCH program clients.

d) Petroleum, Oil & Lubricant (POL): \$1,000

The above amount is to cover POL for travel to the four municipalities to conduct workshops, update immunizations, do schools' physical examinations, conduct special projects for community outreach education/counseling and home visits to follow up clients unable to keep appointments.

TOTAL: \$ 48,767

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2001

State of Pohnpei

PERSONNEL \$ 59,128

A total of \$59,128 is requested to continue the salary of two Head Nurses; one (1) practical nurse; one (1) Dental Nurse III; one (1) Dental Assistant; and one (1) Program clerk. In light of the staff shortage, all program staff will serve in all three (3) program components.

FRINGE BENEFITS \$3,548

This sum is set aside for social security and other benefits due the staff. Fringe benefits for Pohnpei State are based at 6.0% of the total base salary.

TRAVEL \$16,100

A total of \$2,100 is requested for intra-island travel for the MCH staff and other support personnel to go to the outer islands and intermediate areas requiring more than one day's travel to continue the Well Child, Immunizations, Pre-Natal update and other MCH related services. MCH services. A sum of \$14,000 will support the travel of the MCH Coordinator, CSHN Coordinator and MCH staff to attend the off island MCH Conference.

EQUIPMENT (including fixed assets) \$ 7,000

This amount is requested to purchase 2 Pediatric Examination table for the MCH Program and other medical equipment needed for promotion of MCH Services.

SUPPLIES \$ 9,558

a) Medical & Dental Supplies: \$ 8,558

Of this total, \$8,558 is requested to cover the cost of prenatal vitamins and iron tablets and liquid, multi-vitamin drops, Tylenol or Tempra liquid for the children.

b) Office Supplies (Expendable): \$ 1,000

This \$1,000 is budgeted to support office supplies and materials needed to maintain the administrative operation of the MCH Program. This also includes such items as papers, pens, blank cassettes for health education announcements; clinic sheets, towels, soaps, etc., needed to run the clinics.

CONTRACTUAL SERVICES \$10,000

This whole amount will be used for Pap smear costs to be sent to Clinical Laboratories of Hawaii which charges \$10.10 per slide. This amount can accommodate 990 Pap smears.

A total amount of \$1,000 is requested for repair/maintenance of program equipment such as vehicles, air condition, typewriters.

OTHER \$1,676

This amount requested will cover the cost of (a) Printing and Reproduction at \$500; (b) Communication for \$500; and fuel for \$676.

TOTAL: \$ 107,010

BUDGET NARRATIVE JUSTIFICATION

Fiscal Year 2001

State of Yap

PERSONNEL \$38,772

A total of \$38,772 is budgeted for seven (7) personnel in the MCH Program. The slight increase is due to change of staff and the requirement under the Yap State Public Service System Law, which mandates the adjustments of staff salary according to a new salary schedule.

FRINGE BENEFITS \$ 1,939

Of the total personnel charges, \$1,939 is set aside for fringe benefits for the seven (7) staff. This amount includes coverage for social security, insurance and other benefits due the staff. Fringe benefits for Yap State is based at 5.0% of the total base salary.

TRAVEL \$ 9,500

The travel budget request is for 10 trips for the MCH Program. This will accommodate the same number of staff traveling off-island to attend MCH-related conferences, meetings, workshops, and/or training. Out of the total amount requested, \$4,674 is requested to support travel of the

Chief of Public Health, one Public Health Staff Nurse and the MCH Coordinator to Hawaii for the MCH Coordinator Conference; \$1,865 of the same amount will enable the Chief of Public Health Division to attend the APNLC in Palau. The differences of \$2,912 will be used by the Public Health staff Physician, MCH Coordinator, Practical Nurse III and Public Health Staff Nurse to travel to the neighboring island (outer island) to provide needed MCH services to that portion of the population

EQUIPMENT \$ 4,500

This amount is requested to purchase one portable dental unit, portable air compressor, portable lamp for the Dental Health Division to provide protective sealants of third grade children in the school.

SUPPLIES \$ 3,000

Of this total, \$1,000 is requested to cover the cost of all MCH clinics, such as prenatal, well-baby, newborn, etc., and \$2,000 is to purchase needed preventive dental supplies for mothers, adolescents and children. With the absorption of the dental aspect of the Yap Head start Program by the Dental Health Services, the Dental Health Services annual budget is not sufficient to provide the necessary supplies for the children.

CONTRACTUAL SERVICES \$ 2,100

a) Pap Smear costs: \$2,100

This amount requested will contract with the Cytology Laboratory of Hawaii in FY 1999 to process all its Pap smears. CLH will send Pap-kits to Yap in attention of the MCH Coordinator. Pap smears are obtained and sent to CLH for reading and results will be faxed to a dedicated fax machine located at Yap State Public Health. At a cost of \$10.10 for reading one Pap slide, this amount is enough to accommodate 200 Pap smears for all pre-natal first visits, post-partum first visits (two weeks/two months post-partum), and OB/GYN and family planning clients.

OTHER \$1,201

This amount will cover the cost of (a) Printing and Reproduction at \$500; (b) Communication for \$300; and fuel for \$401.

3.3.2 Other Requirements

No materials included

3.4 Performance Measures

No materials included.

3.4.1 National "Core" Five Year Performance Measures

No materials included.

3.4.1.1 Five Year Performance Targets

See Form 11, Years 2000 -2004

Figure 4
Performance Measures Summary Sheet

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
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.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases)			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X
State Negotiated Performance Measures							
SP1) Percent of women receiving services in the MCH Programs who receive a Pap smear.			X				X
SP3) Percent of infants who are exclusively breastfed at 6 months of age	X					X	

SP4) Percent of pregnant women who receive at least one nutrition education and counseling session.	X					X	
SP5) Percent of caretakers of infants who receive at least one infant nutrition education and counseling session.	X					X	
SP8) Percent of pregnant women screened for low hemoglobin at their first prenatal visit			X				X
SP9) Percent infants provided fluoride supplements at well baby clinic.			X			X	
SP10) Percent of children with special needs who have a completed re-evaluation by the CSN Team within the last 12 months.		X				X	

3.4.2 State “Negotiated” Five Year Performance Measures

No materials included

3.4.2.1 Development of State Performance Measures

Based on the analysis and conclusions of the MCH needs assessment, the Health Status Indicators and the development of the MCH priority needs, the FSM MCH Program shall maintain some of the State Negotiated Performance Measures and will replace three of the current measures with three new measures.

SP#1 - Percent of women who receive a Pap smear (Maintain)

SP#2 - Percent of pregnant women screened for Hepatitis B (Replace)

SP#3 - Percent of infants exclusively breastfeeding at six months (Maintain)

SP#4 - Percent of pregnant women who receive nutrition education (Maintain)

SP #5 - Percent of infant caretakers who receive nutrition education (Maintain)

SP#6 - Percent of children in Headstart Programs surveyed for DMF (Replace)

SP#7 - Percent children identified with developmental problems (Replace)

SP#8 - Percent of pregnant women screened for low hemoglobin (New)

SP#9 - Percent infants provided fluoride at well baby clinic (New)

SP#10 - Percent of children with special needs who have a completed (re)assessment by the CSN Team within the last 12 months. (New)

3.4.2.2 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 activity is associated with the priority need to assure the adequacy of prenatal care. The level of service is population-based and the type of service is a risk factor.

SP#3 - Percent of infants exclusively breastfeeding at six months. This measure was maintained because of the importance of exclusive breastfeeding in improving the overall nutritional status of the infant and will also prevent the severe infections that cause the high incidence of acute gastroenteritis and acute respiratory tract infections of these infants. It is one of the priority MCH needs and will help to decrease infant mortality. It is a direct health care service level and the type of service is a process.

SP#4 - Percent of pregnant women who receive nutrition education. This measure was maintained because of the impact that good nutrition during fetal development has on the positive outcome of the infant. A good nutritional status is also important in assuring an adequate supply of quality breast milk for the infant. This measure is one of the MCH priority needs and will assist to decrease infant mortality, increase breastfeeding, and improve the nutritional status of children. It is a direct health care level of service and the type is capacity.

SP#5 - Percent of infant caretakers who receive nutrition education. This measure was maintained because of the importance that good nutrition has not only on growth and development of the infant, but also on the nutritional status of the child and to help in decreasing the incidence and the effects of acute infectious illnesses among children. This measure is a direct health care level of service and the type of service is process.

SP#8 - Percent of pregnant women screened for low hemoglobin. This measure was added 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 directly associated with improving the nutritional status of pregnant women 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#9 - Percent infants provided fluoride supplements at well baby clinic. This measure was added because of the proven effectiveness of fluoride supplementation as one of the primary methods of preventing dental disease when coupled with preventive dental education, improved oral hygiene practices, and changes in personal behaviors and habits..This measure will help to decrease dental disease among children through preventive measures and is a population based service and the type of service is a process.

SP#10 - Percent of children with special needs who have a completed re-evaluation by the CSN Team within the last 12 months. This measure was added 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 an enabling service and the type of service is a process.

3.4.2.3 Five Year Performance Targets

See Form 11, Performance Measures

3.4.2.4 Review of State Performance Measures

No materials included.

3.4.3 Outcome Measures

See Form 12, Outcome Measures

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

The Annual Plan for FFY 2001 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 activities will be described for each of the levels of the services by the population groups.

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 the state public health clinics, 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 services at the prenatal clinics include weight and blood pressure monitoring, all laboratory services including urinalysis, hemoglobin, Pap smear, Hepatitis B antigen screening, STD screening, and Chlamydia screening 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. The cost of contraceptive and family planning services are provided by staff whose salaries are borne by the MCH Title V Program or the Family Planning Title X Program. Contraceptives are provided by Title and the United Nations Population Fund (UNFPA) which complements all U.S. 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.

Kosrae and Pohnpei States have begun extending follow up prenatal services to the community based dispensaries so that the services are provided closer to where the population lives; Chuuk State continues to provide these services at their 68 dispensaries sites with trained health assistants and traditional birth attendants on all the outer islands. 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.

Because of the importance of nutrition education during pregnancy, the plans for this year will be to develop a common system of prenatal education modules to be used in all the four states. Currently, the content of the education depends on the person providing the service and there is no consistency or quality assurance of what content is being provided. A series of educational modules will be developed to be used by the nurse providing the education. These modules will focus on the important educational messages that pregnant women will need to improve their health and the health of the developing fetus. There will be a major emphasis on the importance of good nutrition

For **infants and children**, the promotion of exclusive breastfeeding is an FSM-wide initiative, which requires all newborns to be breastfeeding prior to discharge from the hospital. 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 months 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 mothers discharged from the hospitals that are breastfeeding their infants. The FSM SSDI Project has developed an expanded well baby clinic system of care which will include nutrition education and continue to encourage breastfeeding starting with the first well baby clinic visit. Mothers with infants under six months of age will be encouraged to continue to exclusively breastfeed. In order to assure the consistency of educational messages provided by the MCH staff at the clinic, educational modules and scripts have been developed with health and safety information for each well baby clinic visit. The educational information is developmentally appropriate so that the nutrition component addresses exclusive breastfeeding at each of the well baby visits up to six months of age. At six months of age, educational information will be provided on the types of foods that are high in iron and Vitamin A. These educational modules are also accompanied by photographs of mothers breastfeeding to show the proper holding of infants and of mothers washing their hands before breastfeeding. These photographs are of local women so that the educational modules in Chuuk portrays Chuukese women, and Kosraen women and infants in Kosrae. In addition to the education on nutrition, the issue of the availability of low-cost and high quality foods will be addressed by developing activities with other agencies that provide education and information on nutrition and food production. Collaborative projects will be developed where the MCH program will work with these agencies to help families to plant fruits and vegetables, provide them with information on the nutrition value of the foods that are grown and how to prepare the foods.

For **children with special needs**, the SSDI Project has established a system of care which includes providing any child referred and suspected of having a handicapping condition with a comprehensive medical, health, educational, nursing, and nutrition evaluation as part of the team assessment process. With admission into the CSN Program, the child is eligible for continued medical and health follow up services, and referrals to medical specialty services and clinics. The four FSM states will continue to provide these direct medical and health services to the children referred to the Children with Special Needs Program.

ENABLING SERVICES. The activities will focus on national and state performance measures: (1) Children in the CSN 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.

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 screening services and immunization services.

For **children with special needs**, the four FSM states will continue to assure that every child in the CSN 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

CSN Program, the CSN Physician becomes the primary physician. In addition, because of the close working relationship between the CSN 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 CSN Program will continue to provide home visits and outreach services for children with special needs who have difficulty accessing the CSN 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.

The CSN data show that the MCH Title V Program is not receiving as many referrals as 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 a handicapping condition.

The CSN data also show that children are being referred to the program, receive an initial evaluation and are provided services; however, children are receiving follow-up for individual medical problems, but a comprehensive annual re-evaluation is not conducted. In order to better document the progress and improvements that child has made as well as to identify any new special needs that may have developed, comprehensive re-evaluations for younger children should be conducted on an annual basis. The plans for this year will be to establish the procedures to begin 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 low hemoglobin, (3) Immunization rates of 2 year old children, (4) Teen age birth rates, (5) Protective sealants in third grade children, (6) Fluoride supplements for infants at well baby clinics.

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 Programs including family planning services, first prenatal care visits, post-partum clinics. The National MCH Program has developed a contract with Clinical Laboratories in Hilo, Hawaii that provides the Pap smear kits, Pap smear readings and laboratory results on a timely basis. With this mechanism the percentage of women receiving Pap smears increased from 15.8% to 49.6% between 1998 and 1999. This mechanism will continue for the Year 2001 plans and we anticipate an higher percentage of women will receive Pap smear screening.. 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.

As part of the screening activities in the prenatal clinics, screening for hemoglobin will be become a

priority. Current data from logbooks of prenatal clinics shows that in some states less than 50% of the women are being screened - however, this may be a problem of documentation rather than actual screening. The activities for the Year 2001 plan will include the development of a common set of policy and procedures for the prenatal clinics to address all of the screening tests including hemoglobin, the development of a common set of educational modules with an emphasis on nutrition and iron consumption during pregnancy, a common definition of low hemoglobin and standards for treatment, and a data collecting method to determine the percent of women who are being screened.

Between 25% to 50% of children infected with hepatitis 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 perinatal 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 in prenatal care programs and the infant of any woman with a positive screen shall receive HB Immune Globulin followed by the immunizing infants with the Hepatitis B vaccine. The MCH Program will also continue to assure that infants receive the required three doses as part of the immunization efforts in the well baby clinics.

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. As a primary prevention activity, the MCH Program will continue to provide multivitamins with fluoride supplements to all infants and young children at the well baby clinics. The National MCH Program will purchase these supplements and provide them to each of the four state MCH Programs. The MCH staff will assure that these supplements are given to mothers who attend the well baby clinics at the time that nutrition and oral health education is being provided.

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 continue to provide immunizations at the well baby clinics. During FY 2001, the MCH Program will continue to 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 with special needs with an up-dated reevaluation, (2) Infants born to mothers receiving early prenatal care.

For **pregnant women and mothers**, one of the major problems is the fact that in 1999, less than 10% which is lower than the percentage in 1998 when 20% 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 further the development of the expanded well baby care system of services. During 1999, the Well Baby Care Policy and Procedure Manual, and the parent education modules were developed and implemented in 2000 with clinical forms and data collecting forms. A Newborn Registry data base was developed as a central registry for scheduling and monitoring appointments. For FY2001, some of the main activities will be the training of staff related to growth monitoring with plotting of measurements on the growth curve, routine developmental screening, and the proper implementation and use of the 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 FY2001 are the development of policy and procedures to assure that children already known to the CSN Program have an updated reevaluation performed by the CSN interdisciplinary team. The purpose of this reevaluation is to document the progress and improvement that was the result of the treatment and rehabilitation services. This evaluation will also identify and document any further special needs of the child.

4.2 Other Program Activities

The MCH Title V Program in FSM works closely with other federal programs within the public health sector at both the national and the state levels. Examples of these collaborative efforts are the Family Planning Title X Program, the UNFPA Program, the STD program, the Non-Communicable Disease (NCD) Program, the HIV/AIDS Prevention Program, the Immunization Program, and the Tuberculosis Programs. MCH also collaborates with the Special Education Program in the Department of Education, Headstart Programs, Department of Agriculture, parents support groups, community leaders, women's church groups, and women's interests groups. For nutrition education activities, the MCH Programs work closely with the Family Food Production and Nutrition (FFPN) Program, Expanded Food and Nutrition Education Program (EFNEP), and the Teacher, Child, Parent, Community (TCPC) Program - a school health nutrition curriculum. These agencies are represented in all four states and have developed an interagency group that addresses nutrition issues and education.

The toll-free hotline is not necessary in the FSM. The communication system in each of the states allows

ready access for telephone calls to the MCH Program where the communication system is operational. For the outer islands, a communication system using the radio between the outlying dispensary and the state hospital allows communication with the MCH Program. The FSM is not eligible for WIC, Title XIX - Medicaid, EPSDT, or SSI services.

4.3 Public Input

The public input for the 2001 Title V Grant Application will be accomplished in two phases. In the first phase a copy of the application shall be submitted to the Congress of the Federated States of Micronesia in compliance with FSM P.L. 2-68. The second phase will involve the four State Departments of Health and the MCH Coordinators. A draft copy of the 2001 Title V Annual Report and Annual Application will be provided to the Director of Health of each of the four states. The MCH Coordinator in each state will solicit public input by (1) making local radio announcements, and (2) posting public notices and announcements in prominent locations in the community. These announcements will inform the public that the 2001 Title V Annual Report and Annual Application is available at the office of the Director of Health for review, discussion, and comment.

4.4 Technical Assistance

Technical assistance is requested from Dr. Reginald Louie to visit the four FSM states of Chuuk, Pohnpei, Kosrae, and Yap to assist the MCH Coordinators and the Chief of the Dental Health Division to develop a comprehensive preventive dental program. Recent surveys of Headstart children are showing that approximately 80 - 85% of the children have serious dental disease.